Many Voices, One Agenda

A National Consultation on Advocacy and Monitoring for Women's Health and Rights

A Report

June 26-28, 2002

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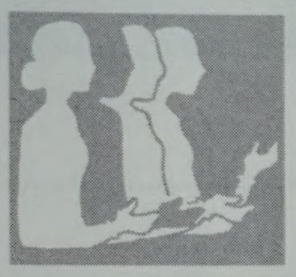
Copies Available at **CHETNA, Ahmedabad**

Copies: 1000, September 2002

Many Voices, One Agenda



A National Consultation on Advocacy and Monitoring for Women's Health and Rights

June 26-28, 2002

New Delhi-India

Organized by

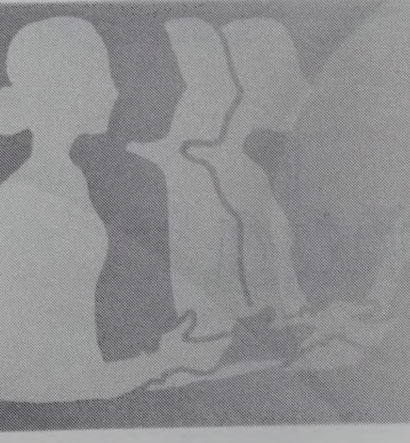
CHETNA
Ahmedabad

SAHAYOG
Lucknow

HEALTHWATCH
New Delhi

Supported by

ARROW (Malaysia); UNFPA-India; National Foundation of India (NFI) and the Planning Commission, Government of India (GOI)



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FOREWORD

The International Conference on Population and Development 1995 was a milestone to reiterate the need to focus on population development for population stabilization. Following this, India declared the National Population Policy 2000, laying down the principle for achieving population stabilization from a comprehensive perspective. However, the implementation of this policy demands creative and effective strategies and regular monitoring of integration of women's health and right perspective.

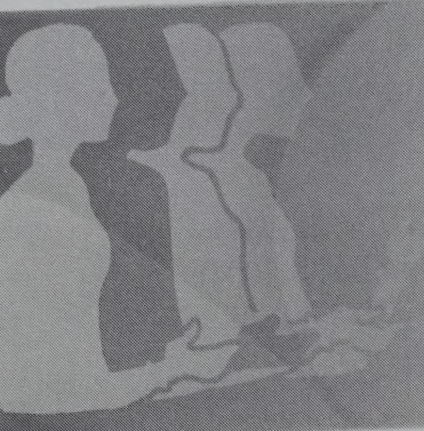
"Many Voices One Agenda", a national consultation organized by CHETNA-Ahmedabad, SAHAYOG-Lucknow, HEALTHWATCH-New Delhi during June 26-28, 2002 at New Delhi, has been rightly placed in this context to ensure the interfacing of women's agenda in national population welfare strategies and programmes.

This consultation report is therefore a prime document, which provides insight in to formulation of state policies, and programmes based on the needs, experiences and inferences of numerous people working for the health and rights of women of the disadvantaged and marginalized sections.

The recommendations proposed through this report will be of immense use to policy makers, academicians, bureaucrats, researchers and donor agencies.

It is hoped that this type of consultation and report would facilitate the successful implementation of the forward-looking strategies and policies.

(J.V.R. Prasada Rao)



Acknowledgement

Many voices resounded together at this National Consultation with a common agenda of Advocating for Women's Health and Rights.

The Consultation has benefited greatly from the valuable contributions of innumerable key organisations and individuals. Every contribution has made a significant impact. However, we would like to take this opportunity to specially acknowledge ARROW-Malaysia, National Foundation of India (NFI), United Nations Population Fund (UNFPA) -India and the Planning Commission of India, New Delhi for their generous support and assistance. The media linkage support from Centre for Media Advocacy and Research, particularly Ms. Sandhya for ensuring significant coverage in electronic as well as print media is also gratefully acknowledged.

Our special thanks go to Ms. Vimala Ramachandran-Trustee- Health Watch for her valuable contribution in the Consultation design, suggestions for resource persons and resource material. Special thanks go to Ms. Rashidah Abdullah - Executive Director - ARROW for her inspiring presence, guidance and motivation which led to the successful organisation of the consultation. Dr. Abhijit Das and Ms. Jashodhara Dasgupta of SAHAYOG-Kriti for their painstaking efforts to facilitate the proceedings and also writing the draft version of the report as co-organisers. Ms. Jyoti Gade from CHETNA for her excellent co-ordination of the logistics of the Consultation. Mr. A.R.Nanda-Executive Director- Population Foundation of India and former Secretary (Family Welfare) to the Government of India for extending his whole hearted support and meaningful contribution at the deliberations.

The successful outcome of the Consultation also owes a great deal to all the presenters, chairpersons and discussants whose names are listed in section five of the report.

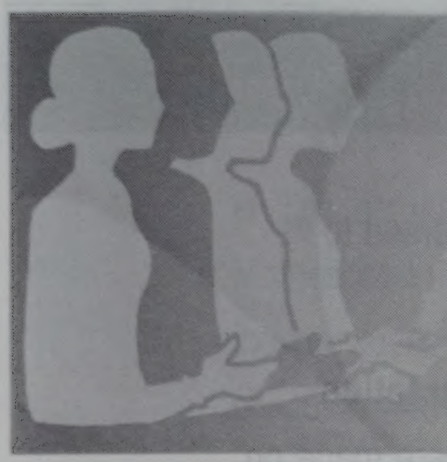
We are indebted to Shri. J.V.R. Prasada Rao, Secretary (Family Welfare) Government of India, for his encouragement and for writing the foreword for the report.

We heartily acknowledge the contribution of all others, who have directly or indirectly contributed in making the National Consultation a success.

Indu Capoor

Ms. Indu Capoor, Founder Director

September 2002



Executive Summary

The consultation brought together individuals, groups and networks from all over the country on one platform who have adopted various creative and effective strategies in advocacy and monitoring of women's health and rights. The objective was to share experiences and identify lessons learnt; as well as explore future strategies and partnerships. Over a hundred participants representing a wide range of stakeholder groups involved in the issue, which included NGOs, Government agencies, International organisations, the media and researchers from ten different states of India, actively participated in the consultation.

The consultation was structured in two sections – the first two days included sharing of advocacy experiences in thematic panels leading to the consolidation of a set of recommendations and future strategies for action. These key actors devoted the third day to sharing these recommendations, concerns and strategies with the government and donor agencies.

In her keynote address, Ms.Rashidah Abdullah, Director ARROW, Malaysia shared a brief understanding of what constitutes advocacy and the significant challenges that advocates had to contend with. She shared the findings of a study on women's health and rights in seven nations in SE Asia, which found that while programmatic changes had taken place since the Cairo and Beijing declarations, the concept of rights had yet to be accepted and internalized. Panel discussions were organised around five key themes:

- Policy Advocacy and Monitoring
- Advocacy for Safe Motherhood
- Advocacy for implementing new Reproductive Health issues
- Advocacy from outside the system, and
- Using information for advocacy.

Each of these thematic discussions included the sharing of a wide range of advocacy experiences from across the country and discussions to cull out the key advocacy lessons. These lessons were later summarized by discussants who were also very experienced academicians and activists in the field. In the last session of the second day, the participants got together in groups and collectively prioritized issues and strategies for advocacy, which will inform their future advocacy efforts.

The most significant outcomes of the consultation were:

- Prioritization of critical areas of concern
- Evolution of a shared agenda for advocacy in the area of women's health and rights
- Understanding roles and responsibilities of all stake holders- NGOs, donor agencies,the state in a rights framework

■ Networking and alliance building among advocates from across the country

LESSONS LEARNT

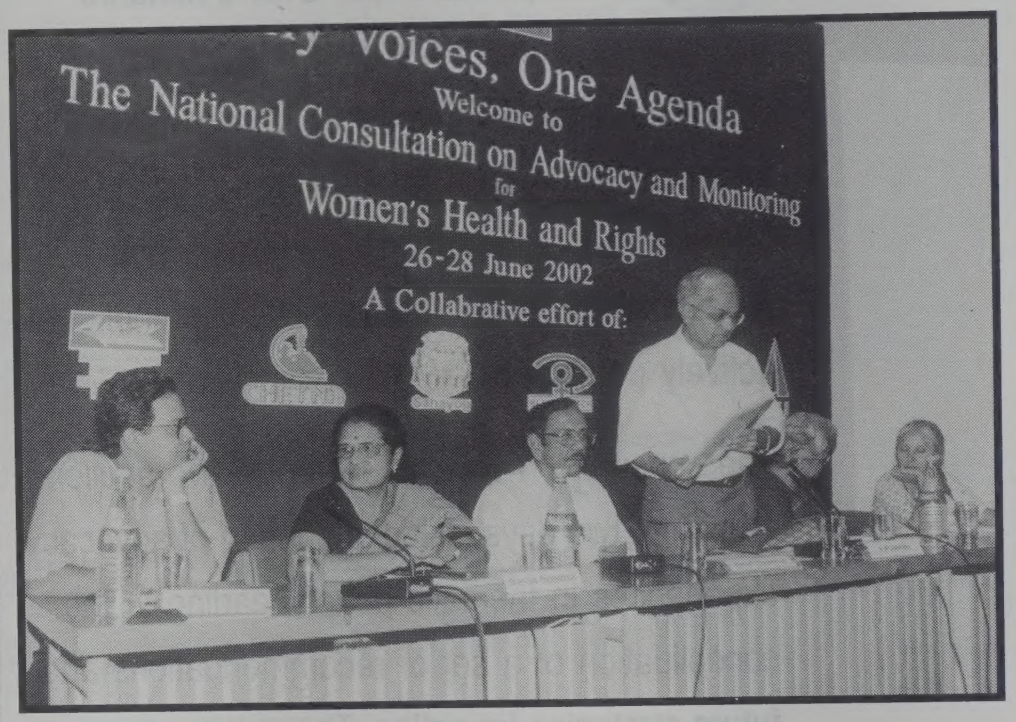
Policy Advocacy - Points drawn from presentations by academicians, activists and researchers on advocating for and monitoring the Population Policies, the Health Policy and the Women's Empowerment Policy:

■ A progressive policy change cannot be limited to rhetoric only; it has to be accompanied by a change in the mindset of all actors. These include not only the actual policy makers but also all those who design programmes to implement the policy and all those myriad functionaries who will actually put the policy into force on the ground. It is also important to transform the prevalent social attitude otherwise the 'progressive' policy change might remain limited to paper.

■ A policy can remain limited to a document if there is no political will to implement it in the form of **realistic resource allocation**. This includes both financial and other resources. Resources are also required for perspective building at all levels to bring about the desired re-orientation.

■ Ultimately the policy should be an expression of the intentions of people's representatives, and therefore ownership of the policy should rest with the people. It is important for people to know what is actually stated in the policy and have the information to monitor the implementation of the policy. Unless the policy is well known, accepted and monitored by the community, it will never be implemented to its fullest extent.

Advocacy on Program Implementation- Points drawn from presentations were made on advocacy and monitoring of reproductive health programmes on familiar issues like Safe Motherhood, as well as newer and more complex issues such as Adolescents, Reproductive Tract Infections (RTIs) and Sexually Transmitted Diseases (STDs), Violence, Gender Mainstreaming and Sexual Health.



While advocating for the issue of Safe Motherhood, it emerged that:

■ Even now there is debate on the most appropriate way to implement such programmes, despite the years of experience. The community-based model of childbirth care is insufficiently evaluated to date, and the crucial role of other back-up facilities has not been adequately understood as is obvious from the access to referral care. Despite this being a life-threatening situation where thousands of women die every year, there is no clear decision on how to save their lives.

■ The actual implementation of Safe Motherhood Programmes is deeply affected by the prevalent socio-cultural beliefs about childbirth and the gender construct of women's status, nonetheless this remains inadequately researched or understood, and does not inform current programme design.

■ The poor management skills of those implementing Safe Motherhood programmes are also responsible for the failure of the programme to reduce maternal deaths .

While advocating for the programme implementation of newer issues such as Gender Mainstreaming, Violence, Adolescents, RTIs/ STIs and Sexual Health, the lessons learnt from the presentations were:

■ Conceptual clarity on these issues is a prime necessity. As these issues are relatively less discussed or researched, definitions and frameworks are still evolving. However, it is important to begin with at least a shared understanding of what is meant by each of these terms.

■ There is insufficient understanding of the groups with whom we seek to work on each of these issues. We need to expand our present level of understanding about women's perceptions of reproductive infections, or about adolescents, or about youth and men who perpetrate violence, and so on.

■ While advocating for programme implementation in these complex issues, it is desirable for the advocate to alliance with someone who is functioning within the system (preferably in a senior capacity) but who is supportive and open to new ideas.

■ For each of these new issues, it is unrealistic to expect that a nation-wide programme will be started all at once. There should be a small action research or pilot programmes, with comprehensive process documentation to explore the modalities. Once again, this needs adequate resource allocation, as well as patience to learn the emerging lessons.

■ Mainstreaming these new issues will be a gradual process and will need considerable perspective and capacity building before the new ideas and approaches are internalized. This also needs adequate resource allocation.

Advocacy from Outside the System – Points drawn from presentations of experiences of the Campaign Against Hazardous Contraceptives, the drafting of a Bill on Domestic Violence by women's groups, the Public Interest Litigation against Sex Pre-selection and the campaign on the Uttar Pradesh Population Policy.

■ When the system fails to monitor itself, the advocates have to step in to safeguard the rights of vulnerable people. Apparently there is a constitutional provision to safeguard the rights of the people; in reality however, even the rule of law may be violated by the state, as was evident from the recent violence in Gujarat. Similarly, the government may enact policies and give assent to international treaties or agreements, and yet violate these in other laws or state-level policies. Then again, several regulatory measures for the private sector may be violated rather than applied, due to inefficient governance. In such

cases, the vigilance and watchfulness of human rights activists and advocates alone can lead to action and redressal.

■ Legislative advocacy may actually lead to changed or new laws, but unless there is an accompanying grassroots movement, the law may not lead to any real change. The community must be informed enough to monitor the implementation of the law.

■ The state is clearly withdrawing from its welfare and regulatory role. But rights cannot be attained without an accountable mechanism to safeguard the rights. In such a scenario, advocates have to identify newer target groups for rights based advocacy.

Using Information for Advocacy - Points drawn from presentations about the sensitisation of journalists on Gender and Reproductive Health, the need for a paradigm shift in Health Communication and the Campaign against Sex Pre-selection.

■ While the media is a crucial actor in all forms of advocacy, the competition from different sources is making it increasingly difficult to get "our"news on centre stage. For example, commercial interests, government announcements, politics and international conflict crowd out women's issues and struggles for rights. The poor coverage by media of a 29-day fast by four people on the Narmada Dam displacement is a case in point.

■ At the community level, the 'right to information' must be actualised. If a critical mass of people are informed about their entitlements and have the data to monitor their rights, it can lead to a quiet revolution on women's health and rights.

■ Advocacy using information needs rigour and dedication. While on the one hand all advocacy should be substantiated by fact and data, as well as by documented evidence, advocates often tend to avoid this rigour and put emotion foremost, which makes it easy to deflect them.

Participants

The participants of the National Consultation were from different states of India, educational background and had varied experience.

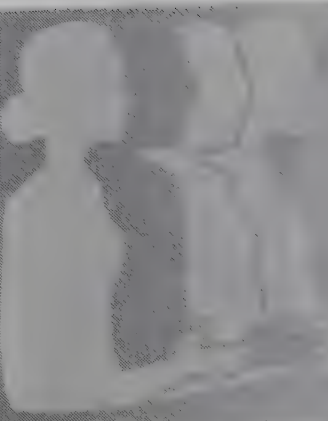
Government: There were representatives from the states of Bihar, Uttar Pradesh, Gujarat, Rajasthan, Haryana and the Centre involved in implementing programmes related to women's health, as well as from the Planning Commission.

NGOs, Women's Groups and Activists: Apart from the panelists, there were grassroots NGOs who were involved in advocating and monitoring women's health and rights from the states of Uttar Pradesh, Bihar, Rajasthan, Gujarat, Uttaranchal, Jharkhand and New Delhi. **Human Rights Organisations** like Human Rights Law Network and Lawyers' Collective also attended the proceedings. Media organisations like the Press Institute of India, PANOS Fellowship Programme and Centre for Advocacy and Research were also part of the proceedings. Apart from that there were representatives from major national health networks like the Medico Friends Circle, HEALTH WATCH, CMAI and CHAI. Service Provider organisations like Parivar Sewa Sansthan, training organisations like NIPCCD, NIHFW and donors like National Foundation of India (NFI) were also active participants.

International Organisations: Apart from Panel Speakers there were representatives from UNFPA, SIDA, IPAS, WHO and MacArthur Foundation.

Media Representatives: There were around fifteen media persons who attended the conference from print as well as e-media.

Researchers and Academics: Apart from independent researchers, academicians from the M.S. University, Vadodara and JNU, New Delhi participated.



Recommendations

The recommendations emerged from presentations and discussion on key issues concerning women's health and rights.The issues were violence, women's development, policy advocacy, maternal health, community health, nutrition and food security, women's rights etc. Amidst a wide spectrum, there was a common consensus while formulating these recommendations. They focussed on the following seven key areas:

Changing the Population Control Mindset

Sex Preselection and the Prenatal Diagnostic Test Act

The Role of Non Government Organizations

Gender mainstreaming was viewed as a cross-cutting issue in all the key areas

Quality of Care for Safe Motherhood and Family Welfare Services

Nutrition and Food Security

Violence Against Women as a Health and Rights Issue

Empowerment of Adolescents

Recommendations for the Government

Population stabilization is a priority concern for the Government of India. The participants expressed consensus and support to the Government on this issue. In order to ensure population stabilization as per the ratification of the Programme for Action, it is imperative that the Government adopts a development approach.

The NPP 2000 should have been named National Social Development Policy rather than a 'Population Policy'

Shri A.R.Nanda, Former Secretary-Family Welfare, Government Of India

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The participants therefore put forth the following recommendations:

1 FOR A CHANGE IN POPULATION CONTROL MINDSET

■ **The policies of incentives-disincentives or coercion should be avoided**. It has been amply proved that such policies lead to violations of human rights, especially of vulnerable groups like women, the poor and the Dalits. All state governments, like the UP government, should withdraw the imposition of method-specific targets. The Government should focus on providing complete information regarding contraception combined with high quality accessible and affordable year-round services for birth control to all women, men and adolescents to enable them to make free and responsible choices about their own family size and generate community demand for services.

■ **Attempts to promote the two-child norm must be discontinued, as the sex ratio** will decline further. When couples are under compulsion to have less children, they will opt for sex pre-selection in order to ensure sons. This is evident from the states like Gujarat, UP, Haryana that have already shown the effects of implementing the two-child norm in terms of an alarming sex-ratio of children under six years.

2 FOR SEX PRE-SELECTION AND THE PRENATAL DIAGNOSTIC TEST ACT

■ The proposed **PNDT Amendment Act** needs to be passed in Parliament in this monsoon session. It must be ensured that **provisions of the PNDT Act and the Supreme Court directives are complied** with. The Act if strictly implemented may be effective in arresting the rampant practice of sex pre-selection.

■ The **system-wide gender sensitization and re-orientation of all departments and functionaries must be undertaken at the earliest.** The present collusion of state machinery in the practice of sex pre-selection (no arrests were made under the PNDT Act before the Supreme Court order) is a symptom of the widespread indifference towards women's right to life, women's social and economic contribution and demonstrates the mindset of considering a daughter a "burden".

■ **Committed NGOs with a track record should be actively involved and given the**

mandate, resources and recognition to monitor the functioning of state actors in the implementation of the Act.

■ The **resources** raised through registration fees of ultrasound machines should be used to strengthen the implementation of the PNDT Act itself. It is commendable that the **state should provide information on the utilization of the four crores allocated** for PNDT Act implementation. Incomplete utilization of funds allocated has often been the cause for ineffective program implementation.

3 FOR QUALITY OF CARE FOR SAFE MOTHERHOOD AND FAMILY WELFARE SERVICES

■ The responsibility for ensuring access to health services for the poor rests with the government. Efforts must be geared to ensure this. While the state is committed to the cause, the present climate of health sector reform may reduce the state's welfare role even for the poorer and vulnerable sections of the population.

■ **It is important that greater accountability, perspective building (especially on gender) and capacity building of all levels of Health Department staff** is ensured so that they may work effectively in a gender–sensitive manner in improving women's access to health care and in promoting men's responsibility in upholding women's health and rights.

■ **There is a need for the state to strictly monitor and regulate the private sector in healthcare** in order to ensure for all citizens uniform standards, high quality, maintenance of ethical norms and right to information. This is all the more relevant as the present policy trends point towards increasing and supporting the entry of the private sector into the provision of healthcare, and the redefinition of health as a commercially viable consumer product rather than as a right.

■ People should have **continuous access to health services.** The Out Patient Departments should remain open till the evening (beyond the usual 2 PM) as it is convenient for the rural communities in far-flung areas, for women and the poor. The services should be provided on a regular basis. "Melas" (fairs) and other traditional/innovative events may be used as additional programmes for public motivation and education.

■ There is an urgent need to strengthen the capacities of Government institutions/centers **in management of health supplies** as logistical problems have often resulted in inadequate and missing supplies and even lives lost.

■ A **Citizens' Charter of Patients' Rights** needs to be formulated for the entire country that should be accepted by the government and widely disseminated.

■ Some staffing and **service delivery norms** need to be modified to suit the requirements of the area (e.g. hilly, tribal and desert areas etc.).

4 FOR VIOLENCE AGAINST WOMEN AS A HEALTH AND RIGHTS ISSUE

■ It is the **responsibility of the state to safeguard women's right to live** a life free of violence, especially if it occurs because of religion, caste, class or gender issues.

■ The central government must **review the present Domestic Violence Bill** that gives the perpetrator the excuse of self-defense to justify the violence. Moreover, the women's organizations have already drafted a more comprehensive Bill, which includes implementation mechanisms. It is desirable that the Government incorporates the same in the existing bill.

■ **Violence against women must be recognized as a crucial issue of women's health** and innovative programmes have to be piloted to address it within the existing healthcare system. Gender, Women's Rights and Violence Against Women should also be mainstreamed in medical curricula, and sensitization programmes conducted for all associated with law enforcement.

5 FOR EMPOWERMENT OF ADOLESCENTS

■ The present reproductive health approach focussing on spacing methods and planned parenthood must be broadened to be replaced by a **holistic life useful curriculum for empowering adolescents**.

■ An immediate **gender audit of all text books** for children and adolescents must be done to include gender sensitive images of women and men.

■ Comprehensive programmes for **gender training of principals, teachers and parents must be developed and executed.**

■ **Existing programmes** for adolescents' nutrition, skill-building and education needs to **be strengthened.**

6 FOR NUTRITION AND FOOD SECURITY

■ India has enough food production to feed more than its present population. **The state must take immediate measures to ensure the access of the poor to adequate nutrition.**

■ The state must **mainstream the nutrition concerns** of women throughout the life cycle in all health programmes and IEC efforts.

■ **Anaemia must be tackled immediately and a red alert declared.** It is an underlying cause for maternal mortality, widespread morbidity and general debility.

■ The **gender dimension of nutrition** has to be widely understood, as inequality in intra-household food distribution is a major cause for anaemia among women.

■ The state must rigorously **monitor nutrition indicators.**

■ **Existing nutrition programmes must be strengthened** such as the **Mid-day Meal** Program in schools, the **Public Distribution System (PDS)** and the **Integrated Child Development Scheme (ICDS).**

Recommendations to the Donors

The participants of the National Consultation recommend the following to the donor agencies:

1 FOR CHANGE IN POPULATION CONTROL MINDSET

■ There needs to be an investment in **sensitizing law/policy makers** on the paradigm shift regarding population.

■ It has to be ensured that the states do not formulate or implement coercive policies or programmes.

2 FOR SEX PRE-SELECTION AND PRENATAL DIAGNOSTIC TEST ACT

■ In order to ensure **transparency and coordination,** NGOs should be informed about money available and allocated for PNDT implementation at the state/district level.

■ There is a need to invest in **capacity building for NGOs to monitor and advocate** on crucial issues of women's health and rights such as **sex pre-selection**

3 FOR QUALITY OF CARE FOR SAFE MOTHERHOOD AND FAMILY WELFARE SERVICES

■ **It has to be ensured that critical indicators/ index for monitoring Quality of Care are developed and rigorously monitored.** There is no clear framework beyond some limited guidelines for contraceptive provision, whereas **Quality of Care** is a complex combination of client perceptions, technical standards and ethical norms.

■ **Investment must be made in capacity building of NGOs and civil society actors to monitor Quality of Care** in health, especially as health sector reforms lead to withdrawal of state roles and increased entry of a poorly regulated private sector

■ **Innovative projects to build capacities of people's representatives at the grassroots level** (through Panchayat) to monitor quality of health care must be supported.

■ Resources must be allocated **for widespread legal literacy**

■ **Resources must be allocated for gender sensitization** of law makers and law enforcement machinery (lawyers, judges, policemen) and health providers

4 FOR VIOLENCE AGAINST WOMEN (VAW) AS A HEALTH AND RIGHTS ISSUE

■ **The process of formulation of critical indicators** to monitor women's access to healthcare and legal redressal in cases of VAW must be facilitated and investment be made in building NGO capacities to monitor these.

■ **Investment be made in facilitating the development of gender-sensitive medical school curricula**

5 FOR EMPOWERMENT OF ADOLESCENTS

- **Innovative programmes** for empowerment of adolescents including action research must be facilitated and supported.
- **Research** on the perceptions of adolescents of various socio-economic strata, regarding their needs must be supported. This is especially required because current program design is based on perceptions of adults. Moreover, adolescents are not a homogeneous entity, and are from different ages, different social, cultural, economic and geographical realities. One program design may not be appropriate for all adolescents.

6 FOR NUTRITION AND FOOD SECURITY

- Mainstream the nutrition concerns of women, throughout the life cycle in all health programmes and IEC material.
- **Support must be provided to tackle Anaemia on a red alert basis.** It is an underlying cause for maternal mortality, widespread morbidity and general debility.
- The **gender dimension of nutrition** has to be widely understood, as inequality in intra-household food distribution is a major cause for anaemia among women. Implementing agencies must be encouraged to address this dimension.
- **Efforts need to be made and supported to strengthen existing nutrition programmes** such as the Mid-day Meal Programme in schools, the Public Distribution System (PDS) and the Integrated Child Development Scheme (ICDS).

Role of NGOs

The government and donors must recognize the legitimate and crucial role of NGOs in advocacy and monitoring for ensuring women's health and rights. This role includes, but is not restricted to:

- Providing conceptual clarity on issues related to health and rights and developing frameworks for policy formulation, program design and monitoring the implementation.
- Highlighting new or emerging issues of concern through research, needs assessment, consultations and other means.
- Developing and implementing perspective building and capacity building interventions in areas such as gender, sexuality, violence against women, adolescent empowerment, client centered approach, quality of care and so on.
- Developing innovative implementation strategies and examples of best practices which can thereafter be introduced into the mainstream health programmes in a phased manner
- Conducting action research, especially around issues that are new or complex, especially on aspects that the government is ill equipped to handle in the present context.
- Conducting research and documentation which will ensure the formulation of relevant policies and programmes and ensure feedback about implementation.
- Providing support to government think tanks, advisory and monitoring committees involved in policy formulation and review, program design and monitoring of implementation.
- Conducting independent monitoring and providing feedback about implementation.
- Raising community awareness about rights and entitlements of women.
- Mobilising communities and women's groups to engage in advocacy and monitoring to ensure that their needs are met and rights are safeguarded.
- Building partnerships and alliances with media, researchers and activists.

Developing a Rights Framework for Women's Health

The Consultation was a landmark effort in raising the question of women's health in a rights framework at the national level.

Health has traditionally been viewed as a 'service', which may be provided at the convenience of the provider, and is also dependent on the extent of the provider's resources and inclination. Of late, health has also been viewed as a 'product', which may be purchased by those who can afford it and can also be marketed in a competitive manner. The

notion of health as a 'right' is relatively unclear, and a host of questions were raised at this Consultation regarding women's health and rights.

- What is a rights framework when we are talking of health?
- Who is accountable for these rights?
- Who else are we addressing in our advocacy efforts?
- How can we monitor the state in the context of increasing privatization and withdrawal of its welfare role?
- What if the state itself is violating women's health and rights?

All the participants contributed in enriching the discussion on these questions during and after the presentations, compelling each other to reflect more intensely on these issues. To begin with, everyone agreed that health was a 'right' and that all women have the right to health. Health rights are derived from human rights, and the right to life is closely related to the right to health. These rights are derived from clearly stated legally binding definitions like the human rights instruments, conventions on rights, constitution and policies. The CEDAW (Convention on the Elimination of All Forms of Discrimination Against Women) is an important instrument that delineates women's rights and the accountability of the state in safeguarding and promoting these rights.

When we are talking of women's health, the rights framework implies that all women are entitled to enjoy a state of overall well-being no matter what their age, social or economic status. This right can be realized only if there is an agency responsible for safeguarding it, who can provide redressal in cases of rights violations. According to international covenants

and the national constitution, this agency is the state. It is the responsibility of the state to ensure women's access to adequate high quality health information and services, to ensure their survival and protection from all forms of violence and to ensure that those women who go through motherhood, do so of their own choice and with complete safety.

The state may not abdicate its responsibility on the basis of cultural practices, lack of resources or incapacity of its personnel. Since women are already at the receiving end of gender discrimination and historically deprived of majority of the rights, the state must play a proactive role in educating women about their own rights and ensuring more space and opportunity for them. At the same time the state must exercise its authority in raising awareness among the community and among its own personnel about women's equality and entitlements. It may take the help of non-state actors to do so, but the state cannot withdraw from its role with the excuse of preserving religious or cultural diversity. There is no such thing as a 'neutral' position as far as women's health and rights are concerned, and the state is obliged to actively facilitate the realization of women's rights. Not to do so would constitute a violation of women's rights by the state. The state cannot discriminate among women on the basis of their age or class or any other distinguishing factor: **it has to ensure that all women attain their rights.**

Moreover, the state is also obligated to provide information about the extent of its intervention to ensure women's rights, and to permit the community especially women to monitor indicators that will reflect the situation of women's rights as a whole. These indicators will require appropriate data that has to be made available by the state. Therefore the right to information is also closely linked with the right to health.

When we talk of rights, our advocacy addresses the state as a key player who can ensure these rights if it has sufficient political will. This includes lawmakers and the enforcement machinery, policy makers, programme planners and implementers. However it is usually necessary to address other important players who can influence the extent to which women's

rights can be realized, such as the donors, media, NGOs, providers and educators. The central role belongs to community opinion makers, especially women's organizations or women community leaders. We also need to advocate first with other NGOs in order to build issue-based alliances with them, after which we can launch collective advocacy strategies.

Advocating for rights has the reverse component of monitoring the attainment or violation of rights. The community itself can monitor the extent to

which women's health and rights have been attained or violated, and engage with or confront those responsible. This perhaps would be the most sustainable aspect of the rights based approach, and the component of information assumes crucial importance here. Communities, especially women themselves, need information on their own rights, the responsibilities of the state and the redressal mechanisms in place. They also need information on policy and law. They can generate their own information at the local level about the attainment or violation of rights. In addition to this they need to access to information from the state about the interventions carried out and the outcomes. The community's capacities can be built to process this information in order to judge whether the state is fulfilling its obligations or not.

The present day scenario however shows some disturbing trends where the state is forging partnership with the private sector for most services without adequate regulatory mechanisms in place. Globalization is heralding the entry of new actors who are more powerful than governments and consider themselves beyond national laws. Global economic processes sometimes compromise the agency of the state, and it becomes extremely unclear whom we can address in our rights-based advocacy. The older strategies are no longer effective with profit –oriented and often unethical players. Much more powerful efforts are required and much larger coalitions, perhaps across countries. Our rhetoric and approaches may need to be adapted to the new scenario although our commitment remains to women's health and rights.

The other and perhaps even more disturbing trend is the failure of the state to safeguard the human rights and women's rights to health through its own machinery. Recent examples include the collapse of administration in upholding the law of the land in some parts of Gujarat, Bihar, Uttar Pradesh etc. The persistent attacks on women's bodies through coercive population control programmes that violate ethics and norms of quality, and sexual assaults on women by the law implementers themselves. When these go unpunished, the state begins to collude with those who are violating women's rights. The process of advocacy cannot then address the state as the 'protector' of women's rights.

These were some of the reflections that emerged from the discussion over the three days of the Consultation. It is hoped that the process of further exploring these issues will be taken ahead by the participants and their fellow travellers.

Summary of the Proceedings of the Consultation

Introductory Session

The National Consultation on Advocacy and Monitoring for Women's Health and Rights began on the 26th of June 2002 with Ms.Indu Capoor, Founder Director, CHETNA, Ahmedabad, delivering the welcome address. She highlighted the importance of advocacy and

monitoring for women's health and rights in today's scenario, where women continue to have very poor access to quality health care services despite the new progressive population, health and empowerment policies.

Delivering the key note address **Ms. Rashidah Abdullah**, an internationally renowned women's health researcher and activist, and the Executive Director of ARROW, (Asia Pacific Regional Resource and Research Centre for Women) based in Kuala Lumpur, Malaysia, highlighted the significant contribution of Indian NGOs in highlighting women's health and rights at the global level. She pointed out that India has been one of the first countries to make policy and programme changes as a part of its commitment to implement the Cairo and Beijing agenda. In her address Ms. Abdullah highlighted three main issues:

- Highlights of a seven country monitoring study in Southeast Asia undertaken by ARROW and its partners,
- Common issues and challenges regarding advocacy and monitoring of women's health and rights in the region, and
- The lessons from a four-country advocacy and monitoring project that ARROW coordinated.

A review of the situation in the seven South East Asian countries (Thailand, Philippines, Vietnam, Cambodia, Malaysia, Indonesia and Laos) coordinated by ARROW's regional Beijing +5 monitoring study revealed that

- With the exception of Philippines, no other SE Asian country had articulated a commitment to women's health and rights within its health, population or women's development policies. Some policy statements including reproductive rights have been made in Philippines and Cambodia.

- There has been little or no increase in the availability, accessibility, and affordability of primary health care services for women in these countries, in fact the cost of childbirth and other reproductive health services has increased due to privatization and health sector reforms

- The maximum progress has been made in adopting a reproductive health approach in place of a population reduction approach especially in Thailand, Philippines, Cambodia and Malaysia.

- Not much attention is being given to informed choice in the area of contraception, and the use of male contraceptives is universally low.

- Hardly any data was available on reproductive cancers, RTIs and STDs, or about the extent of service availability.

- Very little progress has been made on the design and implementation of gender sensitive and rights based reproductive health programmes by both governments and large NGOs such as the Family Planning Associations. In one extreme case (Philippines) many of the progressive measures adopted by the state in 1996 were withdrawn by the state in open consultation with the Catholic Church.

- The area where the largest progress was visible concerned the issue of "Violence against Women", for new laws and service provisions have been made in many of these countries.

She noted that progress has been slow in the area of sexual and reproductive rights because of cultural and religious barriers and resistance. It was also not necessary that excellent policy development would naturally lead to the design of similarly progressive programmes and this needs strong political commitment. Overall, the achievements had been better where there was better Government-NGO collaboration, as in Philippines. This monitoring study also highlighted the importance of developing shared conceptual and operational understanding of issues such as gender equality and equity, reproductive and sexual rights, women's empowerment and so on. Another significant finding was that the **achievement in policy change is most significant when there is collaboration between government, NGOs and UN agencies like the UNFPA.** It is also interesting to note the potential of South-South exchanges for learning and experience sharing both at the level of the government and the NGOs, Ms. Abdullah warned that one of the crucial determinants of women's access to health services would be the impact of privatisation and health sector reforms, and this needs to be monitored carefully, particularly by women's groups.

Speaking about advocacy and monitoring on women's health and rights in general, Ms. Abdullah emphasized the importance of defining the advocacy goal clearly. Advocacy is different from Information Education and Communication or training or service delivery and this needs to be clearly understood. While advocacy goals will be different from country to country and even from province to province, they should focus on the communities' entitlement to need-based, quality, affordable and accessible services. Since Cairo and Beijing, women's

NGOs have been very active in advocacy from within the system and this has been possible because the Cairo Programme of Action and the Beijing Platform for Action have clearly highlighted the importance of involving NGOs. This legitimacy or a **window of opportunity** has sometimes been very useful but should not or remain the only advocacy strategy. Strategies for advocacy from outside the system include public mobilization and resistance, leading to demonstrations and petitions. Media advocacy can also be a very effective strategy. Networks, coalitions and alliances and learning lessons from others are also crucial for advocacy efforts to succeed. Ms. Abdullah highlighted the important role of information in the advocacy process and pointed out that it was necessary to adopt a range of strategies to ensure success.

Concluding her address, Ms. Abdullah drew the attention of the participants to some of the key lessons that had been learnt from the four country advocacy and monitoring project that ARROW had coordinated. Some of the lessons were:

1. There is a need for evolving a clear operational definition of advocacy acknowledging working from both within and outside the system

2. Specific advocacy goals must be developed, these must emerge from a systematic problem identification and planning process

3. It is important to involve the affected, including the community women if possible, in the planning and implementation process

4. Advocacy action plan should include working at different levels – local to national, and adopt a range of strategies – both from within and outside

5. Capacity building and a learning agenda should be built in the advocacy process

6. Advocacy achievements need to be documented and evaluated and there is a need to develop indicators

7. Advocacy is a long term process towards change and this needs resources and donors need to support advocacy initiatives

Ms. Abdullah expressed hope that with the increasing participation of women's NGOs in the advocacy process, the development of effective partnership and with the opening of spaces within the government, there will be strengthening of the NGOs and the women's movement in the region.

Introduction of Participants : All participants at the consultation introduced themselves. (For the profile of organisers, panelists and participants, please refer pages 42 to 47).

Policy Advocacy and Monitoring

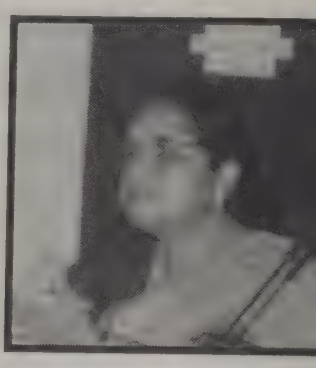
Mr. A.R.Nanda, who till June 2002, was the Secretary- Family Welfare, Government Of India (GOI), chaired the session and introduced the issue. He questioned whether one realizes that women's rights are a part of broader human rights and whether women's rights figure in the language and content of major policies in India? He also asked whether these policies were in the best interest of women. Drawing on his long experience in the government and in the policy formulation arena he pointed out that policy formulation at best is a process of compromise because it includes a dialogue with a large group of stakeholders each with different interests. While acknowledging the need for change in policy he also emphasized that it is important to develop methods for monitoring the implementation of the policies. He gave the example of the National Population Policy (NPP) 2000 where despite the change in the language and intent, demographic indicators such as the Total Fertility Rate (TFR) and Contraceptive Prevalence Rate (CPR) continue to be benchmarks of success. In his opinion these indicators were often anti-women.

In her presentation on the paradigm shift in India's population policies, **Ms. Vimala Ramachandran** started by saying that the term 'paradigm shift' was no longer relevant because of the recent efforts by some influential sections to bring back a coercive population control regime. She highlighted the fact that while population is about people, their livelihood, security (that children will survive) and quality of life, there is an overwhelming concern for numbers and contraception. There is also a widespread lack of understanding that the situation has changed, and because of the phenomenon of 'population momentum' the drop in the growth rates will take two generations before the results are evident. There is also a clear lack of concern for issues like quality and access. The current political agenda seems to be not the removal of poverty but the removal of the poor. While the NPP 2000 indicated a shift in approach, there is a growing voice that it is weak and ineffective and should be replaced by coercive measures. Fortunately there is evidence (including the north Indian states) that population stabilization will occur because women do not desire many children, and only need accessible and quality health and family planning. The need of the hour was to inform influential people about this and counter all efforts to bring back 'population control'. There was a need to view this as a primary health care issue and all concerned citizens and not just women's organizations needed to make efforts.

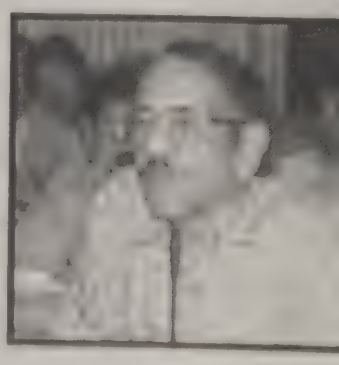
Dr. Mohan Rao shared the experience of the Jan Swasthya Abhiyan (People's Health Campaign) and its impact on the National Health Policy (NHP). The Jan Swasthya Abhiyan was a national campaign on people's health which reviewed 'Health for All by 2000' commitment. The draft of the NHP 2001

was released in the immediate aftermath of the campaign and an excellent critique with alternative suggestions was provided to the ministry on behalf of the people of India. Unfortunately there was very little impact of these suggestions on the policy when it was finally released. In his opinion it is very difficult to influence these policies or subsequent programme implementation because lack of resources and poor investment in the social sector, and the reduction of net flow of resources from agencies like the World Bank to poor countries. He showed evidences of how this drying of resource in poor nations resulted in the increase in global income disparities, increase in Infant Mortality after Structural Adjustment Policy and diverging life expectations between rich and poor populations.

Ms. Meenakshi Dutta Ghosh who was associated with the formulation and implementation of the population policy across the country provided her opinion about its strengths and weaknesses and also shared experiences of how it was working across different states. At the outset she clarified that while the paradigm actually shifted from top down, some of the mechanisms adopted had been counter-productive. For one, the Target Free Approach had been mis-interpreted and even the present CNA approach was not a method of assessing community needs but a statistical exercise. She emphasized that decentralization was a core tenet of the NPP 2000 and communities had to be involved in articulating needs and monitor program implementation and evaluate outcomes. She viewed the recent Supreme Court judgement on the PNDT Act as a significant example of GO-NGO partnership which had also galvanized the civil society into a monitoring role. She also mentioned a number of examples, projects and schemes where the government was opening up spaces for NGOs and civil society to participate and take lead in activities.



Speaking about the **National Policy on the Empowerment of Women (2001), Dr. Sarala Gopalan** stressed that these policies can only succeed if the mindset changes, otherwise they would remain much like the constitution of India- good, pious and neglected. Thus advocacy should not only restrict itself to the policies and programmes but address issues like mindset, social value system and behaviour change. She mentioned that implementing new programmes becomes difficult not only because of entrenched mindsets but also because of inadequate delivery systems. Dr. Gopalan said that it would be difficult to implement the very progressive ideas mentioned in the NPEW without changing the mindset and social system in which son preference above all leads to devaluation of daughters.



Dr. Badri Saxena pointed out a number of shortcomings in the currently used indicators for monitoring population and family planning. He said that there is inadequate disaggregation of data and no data for monitoring activities. Above all,

the data does not reflect local needs and requirements. Different departments collect information in their own way and there is no effort at collective analysis at the peripheral level. He emphasized the need for developing and routinely using indicators to measure client satisfaction, and managerial/system performance and suggested some indicators which can be easily developed using the information that is collected today. He highlighted the need for involving all concerned stakeholders in the collection and analysis of data to ensure transparency.

Discussion- *A* participant raised an issue that while quality of life was important in the context

of population and development policies, it was necessary to keep the issue of numbers in mind. This sparked a lively discussion in which the panelists pointed out that the situation is particularly grim where even though the state has achieved first position in the implementation of the 20- Point Program, the indicators on Family Planning show no significant change. Numbers need to be considered, but in a context and not for just creating a scare or for justifying control. **There needs to be an understanding of quality and this has to extend beyond numbers.** It was pointed out that while literacy was extremely high in Kerala, the same could not be said about the quality of education or its impact on empowerment of women. While the norm for student – teacher ratio is 1:25, it was over 1:60 in Kerala.

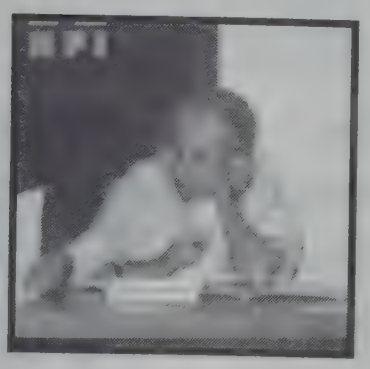
> *The formulations of policies as well as their monitoring needs to actively involve the people. I have been the part of the process where women have actually done so. Community should no longer be considered a passive recipient.*
>
> *Ms. Shashi Prabha, CUTS-Chittorgarh; Rajasthan*

Ms. Suman from Bihar pointed out that though there are provisions for including NGO representatives in Government committees, experience reveals that the most **qualified or representative persons or organizations are never invited on Government committees.** One participant drew attention to the fact that health related policies for women do not pay adequate attention to nutrition.

A participant who had been part of the Jan Swasthya Abhiyan (People's Health Movement) pointed out that advocacy is often a one-sided effort with very little interest towards change shown by the government. When officers change one needs to start the process all over again.

One participant shared her concept of advocacy where one needed to define one's aspirations in terms of what change is required, understand what provisions already exist and ask for their implementation and finally identify

gaps in the implementation and advocate for change. She also added that women are blamed for too much of what is wrong at the family level and **there needs to be awareness generation at the community level as part of any advocacy effort.**

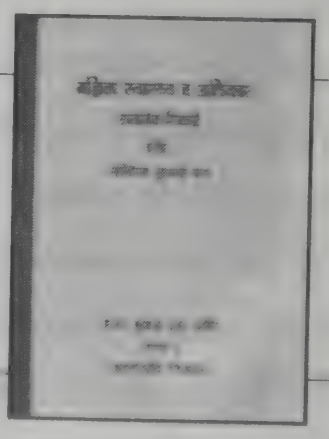


Summing up the very enlightening presentations and the rich discussions **Imrana Quadeer** pointed out that it is important to first determine what one is advocating for and whom is one advocating with. It is all right to advocate from within the system, but one must always be conscious of the voices and concerns of the people, and these need to be Centre-staged. It is necessary to situate women's health within the context of the dignity of women as an individual and as a citizen. But to do so, it is important to also talk of politics and economics because health is closely related to these too. It has to be understood in the context of how the health sector has been transformed from a not-for-profit service sector to a profit oriented market. Such a health sector is bound to be anti poor and technocentric. She highlighted the three major issues for advocacy that she saw emerging from the discussions . These were:

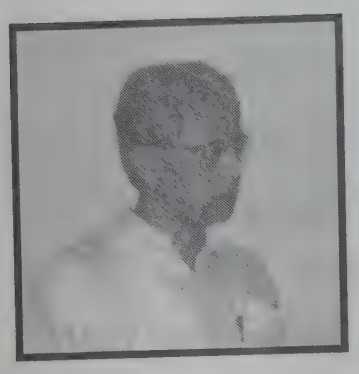
- the **right to information** about one's health and services from the health department and Ministry and the population commission
- to ensure that people are able to participate at all levels and
- to demand accountability from the health services (it is not enough to have indicators).

She concluded by reminding all participants that it was essential that one applies the same standards to one's own actions.

The session concluded with the release of an Advocacy Briefing Kit in Hindi language on Women's Health and Rights which had been published by SAHAYOG, Lucknow.



Initiatives in Safe Motherhood



Dr. H. Sudarshan, of Vivekananda Girijana Kalyan Kendra, Karnataka chaired the session and introduced the issue through sharing some personal experiences. He pointed out that despite the fact that a large number of changes had been introduced through programme and policy, safe motherhood still remains a distant dream for most of India. Through his association with the Lok Ayukta in Karnataka as the Vigilance Commissioner for Health, Dr.Sudarshan has seen the dismal state /persona of the public health care delivery system where there is rampant corruption even for performing basic duties. He was firmly of the opinion that the public health care system is the only viable system for ensuring safe motherhood and role of the voluntary agency in this regard is minimal. The key persons would continue to be the Government multipurpose health workers and the appropriately trained and skilled midwives.

Ms.Uma Handa presented the outlines of a community midwife project that UNICEF, in collaboration with the Ministry of Health and Family Welfare, Government of India, is developing and wishes to pilot in some states of the country. The focus of the project is to train and equip local persons as community midwives, and ensure community participation as well. **Ms. Bhattacharya** strongly urged that midwifery practices and training should be strengthened. In her experience the trained nurses lack sufficient experience in safe delivery despite their training. She viewed a clear role for midwives in the implementation of safe motherhood programmes. **Dr. Biswal** of the Ministry explained the new RCH programme in detail highlighting the different provisions that had been made to ensure safe delivery.

Dr. Pankaj Shah shared the experience of an NGO managing a First Referral Unit (FRU) of the Government of Gujarat. It was his contention that without a properly functioning FRU it would be very difficult to ensure safe motherhood. At the same time the FRU cannot function without community involvement and support of the Anganwadi (crèche/preschool) workers, Dais (India's Traditional Midwife / Traditional Birth Attendants) and village leaders. Community awareness and involvement, family readiness and Dai training form the core of their successful experience. Some of his suggestions for the successful operation of a FRU included sensitizing of staff, developing linkages with private practitioners, respecting TBAs and their referrals, setting up of routine Antenatal Care clinics and having a functional ambulance service. This needs to be supplemented with a strong community awareness programme and emphasis on safe home delivery and recognition of danger signs.

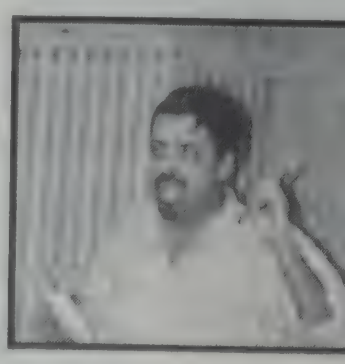
Ms.Aparajita Gogoi described the experiences of the White Ribbon Alliance India, which organized a year long campaign on safe motherhood in

2001. The focus of the campaign was to create awareness about maternal mortality among families and communities and to inform families and husbands what action they could take to prevent maternal death. Some of the strategies adopted included organizing symposiums and workshops, arranging exhibitions, competitions, rallies, and organizing a march to the Taj Mahal, which is not only a symbol of love, but also a testimony to a maternal death. They also advocated with the government for mandating the declaration of a 'safe motherhood day'. One of the impacts of the campaign has been to initiate grassroots efforts in various north Indian states.

Vd.Smita Bajpai, centre-staged the critical role of the Dai (India's traditional midwife / Traditional Birth Attendant) in efforts to ensure safe motherhood in India. She felt that there is the need to acknowledge that safe motherhood is not merely a health issue but a social issue as well, and social mobilization is necessary to bring about changes in the gender-power relations, which in turn can affect safe motherhood. She was of the opinion that there needs to be a strong linkage developed between community needs and safe motherhood services. The Dai is in a unique position to be this link person. The Dai can deliver up to 70% normal births while there needs to be an effective, affordable and accessible referral system, which can deal with the complicated cases. Sharing CHETNA's experiences of over a decade in promoting safe home based deliveries she expressed the need for recognition, strengthening and support to Dai. She concluded that the practices of the Dai had not been adequately studied and this was crucial for planning future strategies.

The discussion centered on primarily three themes – the need to acknowledge **safe motherhood as a part of right to life.** While many of the presenters had given remarkable statistics to reveal the urgency of the problem very little was being done in the way of demanding accountability for the 125,000 women who needlessly lose their lives each year. One participant mentioned that it was difficult to get the states to acknowledge that maternal mortality was rising and a possible reason could be that the person who reported maternal deaths got punished. The second theme was around home based deliveries and understanding the **cultural aspects of pregnancy and childbirth.**

> *Childbirth at home is not just a biological even but a cultural one as well and this needs to be understood carefully before prescribing any home based delivery intervention.*
>
> *Dr. Abhijit Das, SAHAYO*



Similarly, mother's nutrition, which is a crucial determinant of safe motherhood, is not just an issue of prescribing iron and folic acid tablets. The Dai's role also needed deeper understanding and efforts. To strengthen her should be within the socio-cultural context and should be supported by **effective and quality referral systems.** The potential role of NGOs in managing referral

centers was also discussed. Two participants who had been involved in running Primary Health Centers shared that though the Government now released advertisements inviting NGOs to take over the running of PHCs, it would be difficult without significant autonomy to make any impact and required adequate financial resources as well.

Overall, the participants unanimously felt that **quality of care at the Primary Health Care centre needs to be substantially improved** if safe motherhood is to become a reality in a country like India.

There is a need to clearly identify the strengths and limitations of the numerous healing systems and advocate for a plural health system.

Ms.Shashi Prabha, CUTS, Chittorgarh, Rajasthan

Dr. Shyam Ashtekar summed up the discussion on safe motherhood pointing out that advocacy needs to be done at five levels, three at the level of the community and two at the level of services.

■ The first issue is within the family: One needs to understand why there is so much widespread anaemia despite iron and folic acid supplements, why there continues to be over work, why do families persist with so-called unsafe practices and similar issues, and one should advocate for a change.

■ The second is at the level of uptake of services - one needs to understand why the communities do not feel the need to consult the ANM and advocate accordingly.

■ The third community level issue that needs to be advocated is the reluctance by the community to take the woman to a proper referral centre and on time.

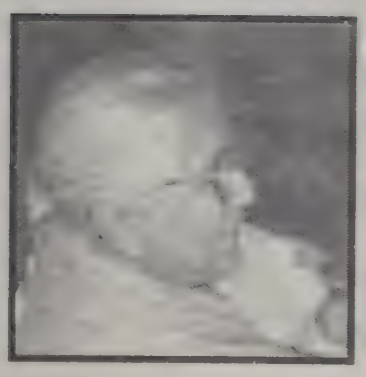
■ The first of the two service level issues related to the functioning of FRUs, because the FRUs were still mostly defunct where they had been created.

■ The final service related advocacy issue, which needs to be strongly advocated is: who will provide services at the community level – what will be the role of the ANM and the TBA?

He related an instance where an official of the Department of Family Welfare had said that the Auxiliary Nurse Midwife (ANM) could not be expected to conduct deliveries. He was disappointed with the Government approach of again considering appointment of a new person whenever a new problem was identified – and he wondered whether the newly proposed **Community Midwife** would not end up being the same.

Safe motherhood needs to be considered within the framework of primary health care and advocacy efforts should focus on the responsibility of the government to provide these services at an affordable cost to the community.

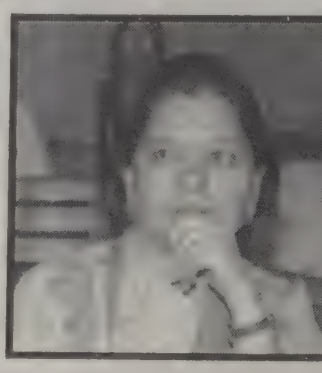
Advocacy for change in Programme Implementation – Incorporating New Reproductive Health Issues



Dr. Sharada Jain, the Chair for this session, drew the attention of the participants to core issues of the rights approach and its linkage with monitoring. Dr. Jain said that when one perceives health as a rights issue one should view the clear linkages with the right to information – the information about policies, programmes and provisions that are being made for the poor. Change will be possible if there is a pressure for greater transparency from above while there is an equal demand for information from below- and this is the challenge that advocates must address. Talking about a new approach to health, she shared that when defining health one talks about the overall wellbeing but this aspect gets lost in the obsession with the body and the social and mental dimensions of wellbeing are seldom discussed.

Ms. Firoza Mehrotra underlined the importance of working with adolescents not only because they are in such large numbers (roughly 23% of the population) but because they are going through a process of physical and emotional change and at the same time performing varied reproductive and productive roles. She indicated different adolescent concerns and shared a blueprint of how one could work with them.

Sharing his experiences of working with adolescents in West Bengal, **Dr.K. Pappu** highlighted the importance of understanding adolescents' own perspective and the diversity of adolescents – married, unmarried, in school, out of school, rural, urban and so on. In order to work with adolescents, it is important not only to provide services but also to advocate with teachers, school management and obviously the family, the community and service providers.



Focussing on empowerment of adolescent girls, **Ms.Pallavi Patel** mentioned that early marriage was the ultimate form of discrimination, yet around half the adolescent girls in the country are married before the legal minimum age. She shared experiences of an empowerment intervention with girls to enable them to negotiate myriad forms of gender discrimination and not merely increase their knowledge of reproductive health. She stressed the importance of a multi-sectoral approach and of having facilitators who are open to weave the concerns of adolescents in their programme.

Dr. Seema Malik and **Ms.Padma Deosthali** shared their unique collaborative experience of running a Crisis Centre for women facing domestic violence in a large Mumbai public hospital. Their presentation put on board the practical aspects of implementing a new Reproductive Health issue. It is not enough to just introduce a new issue but it should be backed by infrastructure and services administrative commitment, bureaucratic flexibility, re-orientation of approach

and service delivery system and collaboration with other stakeholders and experts like NGOs.

If violence against women has to be incorporated into the public health system there must be a system wide readjustment- it should be part of the curriculum, there should be ongoing training, the Out Patient Department (OPD) and Management Information System (MIS) should be re-organized, referral departments established and finally it should be backed by community outreach. Getting the doctors and other staff on board is also crucial, as they do not view gender discrimination and violence as a health issue. They also advised that before replicating the experience on a large scale, smaller pilots should be started and their impact and effectiveness studied.

Gender mainstreaming has been a crucial crosscutting issue to implement the paradigm shift in population and reproductive health programmes.

Ms. B. Bhamathi presented her experience of working through the UNFPA system to mainstream the gender perspective into the Ministry of Health and Family Welfare. She mentioned perspective building and capacity building as her two major strategies, which had been tried out in several states and at the Centre. She pointed out that effective mainstreaming of a new issue needs a sympathetic person within the system who can support the changes as well as allies who have the required expertise. She recounted working closely with a team of gender experts from the NGO sector who worked with her to prepare modules and manuals so that trainers could be created within the system itself. It had been a challenging process to introduce the gender perspective into a Ministry and a department that was largely resistant and had always worked on a gender-blind population control approach, where gender was seen as a "women's matter", and never as a cross-cutting issue. The process was resource intensive and slow, and training follow-up could not always be ensured.

Nonetheless, there had been rewards in terms of sensitized personnel in key positions, and in the module being not only used in every level of health provider training but also used in the Probationary Course for the Indian Administrative Service Officers at Lal Bahadur Shastri Administrative Academy. Moreover she pointed out that since perspective building had actually not been a major budget head in the original program, she had to be very ingenious in capitalizing on all possible spaces and resources available to ensure that the work expanded to the fullest extent possible. A major lesson learnt was that even hierarchical formations are amenable to gender mainstreaming if we have the persistence, competence and skills.

Ms.Sunita Kujur made a presentation of her organization's efforts to work on the very little known and difficult area of Sexuality and Sexual Health. She explained that conceptual clarity was important as these subjects were enmeshed in a web of myths and misconceptions. It was even more

difficult to enable a perception of sexual health as a state of pleasure and enjoyment rather than within the disease framework. She also mentioned the ways in which the organization was trying to bring these into the realm of discourse by running a helpline, and trying to make a case for mainstreaming such interventions by meticulously documenting all calls for information or assistance.

The final presentation of this session also shared the experiences of another collaborative experience within the Brihanmumbai (Bombay) Municipal Corporation on providing RTI services. Despite having an impressive infrastructure the services of the dispensaries and health posts were not being utilized by women for their reproductive health problems.

Ms.Renu Khanna and **Dr.Usha Ubale** shared some of their advocacy efforts to ensure that a wide range of quality and gender sensitive services are available to women. The project has worked at both the community and service delivery level to generate a sense of ownership. In order to involve health care providers at all levels the project has invested in training, workshops for senior officers on quality and gender, regular briefing meetings, formation of committees and task forces, working with unions and publishing of a newsletter. The presentations highlighted the difficulties of working with hierarchical structures, rigid mindsets and last but not the least shrinking financial resources. Three key advocacy lessons from the project were:

i) advocacy is most successful when the advocates are persons within the system
ii) when advocacy should focus on all tiers involved and not just the top management, and
iii) good IEC material can be a great support to advocacy.

During the discussions, a number of very crucial issues emerged that needed to be considered in the light of the new issues that had to be included within the overall ambit of the Reproductive Health Program. There was a discussion on **sexuality and sexual health** in which participants highlighted the need to advocate for the inclusion of sexuality and sexual health within curricula for adolescents and for service delivery. This is particularly important considering the dual standards and attitudes concerning sexuality in the community and within service systems. Other participants pointed out the importance of linking sexuality with violence. Still others mentioned that when dealing with adolescents or with sexual health we need to remember adolescent sex workers also.

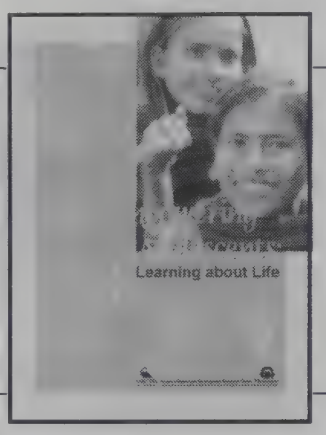
There was some discussion on **violence** and options for advocacy when the state becomes a major perpetrator of violence against women, as can happen in police stations, hospitals, protection homes or even in riot situations as in Gujarat. The issue of monitoring **quality of care** in the context of violence related health

problems was also raised. The discussion was broadened to include issues relating to quality of care and **accountability** of public health systems. The strategic importance of working with some individuals from within the system was mentioned by a participant but at the same time the importance of working for **mobilizing women for claiming their rights** should not be underestimated. In terms of operationalising a gender sensitive approach it is essential to

enhance capacities and build a gender sensitive perspective. The participants mentioned the importance of learning from others' experiences both within and outside the country and importance of involving NGO partners.

Dr. M. Prakashamma, in her summary pointed out that while advocating to secure women's health and rights it is essential to first have conceptual clarity about what was a rights framework when applied to health and how it applied to program design, implementation and monitoring. It is also important to have a holistic understanding of the new issues, and their complexities, - be it adolescents, sexual health or violence or Reproductive Tract Infections. This will sharpen the advocacy for programmes to be designed and implemented in a more effective manner. It is also necessary to advocate for greater research, including social research, into the new issues to understand them in a comprehensive manner. On a programmatic level it was very important to record information and develop a Management Information System which would enable understanding the extent of the problem and the impact of the changes to be recorded. She reiterated the importance of perspective building and pointed out that this should include both a people-centered and gender sensitive approach. The ultimate challenge of advocacy was to integrate these new changes within mindsets, policies, and programmes and also within the society at large. It was not enough to advocate with the government: it was imperative to advocate with communities and build up a movement.

The session concluded with the launch of the book: Empowering Adolescents, Learning for Life, published by CHETNA.



The second day began with Ms. Renu Khanna sharing her concerns about advocating for women's health and rights, in a situation where there is complete breakdown of constitutional machinery, and the state is not only unable to protect women's health and rights, but becomes an active agency in perpetrating the violence. This concern about the role of the state in condoning and even sometimes perpetrating violence while at the same time not having adequate redressal mechanisms on issues relating to violence and women's health and rights, recurred throughout the fourth panel discussion.

Advocacy from outside the system

Ms. Nirmala Buch chaired this session and in her remarks noted that while some debate was possible on service issues there seemed to be a totally closed mindset when it came to considering women's health as a right. Campaigns on sex-preselection and population control have resulted in some successes at the policy level but firmly entrenched mindsets prevent these policies and laws from being effectively implemented. Changing attitudes was an important challenge for enabling advocacy from outside the system. These efforts also help the progressive individuals within the system to push for changes in laws, policies and programmes. One of the most important agenda for advocacy from the outside was to ensure that the state did not backtrack from its commitment to uphold women's health and rights that it had made through international commitments (Convention on Elimination of all forms of Discrimination-CEDAW, International Conference on Population and Development -ICPD, Fourth World Conference on Women-FWCW) and national policies like the NPP-2000 and the National Policy on Empowerment of Women- 2001.

The first presentation by **Ms. Vani** highlighted the different campaigns by the women's health activists to secure women's health and rights. She mentioned that there is a tendency in India to view women's health problems from a narrow tunnel vision of family planning and population perspective, whereas women's health activists were opposed to coercive population control and believed that birth control should be the right of all women. She mentioned the campaigns against long acting Injectable Contraceptives, Quinacrine, sex-pre selection and the one against the hysterectomy of mentally challenged women. These campaigns had led to some successes like delaying the introduction of long acting hormonal contraceptives, and preventing it from being part of the Indian Family Planning Program, banning of Quinacrine, introduction of the Prenatal Diagnostic Technique act and formulation of ethical guidelines for research. Strategies adopted for these campaigns included direct action, filing petitions in the court and taking the assistance of the media to put the debate in the centre stage of public domain. Some of the challenges faced in these campaigns have been understanding and dealing with technical medical jargon, legal processes and strategies, and even developing technical competence to present counter-examples. Besides, there were difficulties in integrating multiple stakeholders such as the community based organizations, doctors, NGOs, involving the media and adapting to new situations like globalization where market forces lead to the entry of new actors into the advocacy arena.

Speaking on the PNDT Act and the subsequent Public Interest Litigation for ensuring its

implementation, **Ms.Sumita Menon,** first acknowledged the contribution of various individuals who have relentlessly worked on the issue. She traced the history of the campaign on sex pre-selection to the point where the Central Act was passed. This was also the result of sustained advocacy. But a law was not enough because the patriarchal norms in society ensured that people still wanted sex-selection, so doctors felt justified in providing this support and the state remained silent. The Public Interest Litigation has been effective in some ways in getting governments to act, but the task is still uphill. Implementing the monitoring mechanism, interpreting the legislation and ensuring women's right to survival are aspects that still need to be worked out. She pointed out that such campaigns need an enormous amount of energy, and time and commitment to the issue. It often becomes difficult to work together when there are different points of view which are not resolved and this affects the kind of pressure that can be applied from outside. There was also the challenge of dealing with new and emerging technologies, which can subvert the text of the law.

Finally she expressed her opinion that in the context of the recent experiences of violence against women in Gujarat, there are no longer clear answers about what kind of advocacy is effective and for whom.

Advocate Indira Jaisingh, started her presentation on advocating for a new law on domestic violence, with the reflection that there has been a complete silent degeneration of the system of governance and constitutional machinery over the last fifty years. What is happening in Gujarat where the right to life itself is being violated, is only the culmination of a process. She framed her presentation in the fact that there was a need to frame a new law in order to situate domestic violence within the context of rights and not within the context of "preserve the marriage at all costs". Ms. Jaisingh felt that there was the need to build in mechanisms and structures to ensure transparency and monitoring within the law-making process. Some of the strategies that have been followed include consultative processes to build consensus, working with the government, and parliamentarians. One major pitfall of working with the Law Ministry was that it first invited them to make a new law, apparently took their suggestions and then framed a totally different law. This meant that they had to oppose government action, set in motion a second round of consultations, critique the government law and frame an alternate law. Arranging for resources for the entire effort had been a major problem. She pointed out that consensus building among women's groups and NGOs was vital for the success of this effort.

The concern for sheer numbers over people has always been foremost in UP, and the UP Population Policy clearly violates women's reproductive rights. **Ms.Jashodhara Dasgupta** presented a paper entitled "Safeguarding Women's Health and Rights-Advocacy on the Uttar Pradesh Population Policy

2000" that shared the experiences of the campaign on the population policy and quality of care of family planning services. Some of the strategies that were used included informing and educating people about the policy, writing open letters to some of the key bureaucrats and policy makers, capacity building among NGOs for advocacy and monitoring, conducting an opinion poll among community leaders, documenting case studies of system failure and a public hearing. Media advocacy formed a strong pillar of the entire campaign. As a result of this campaign a strong network was built up, the capacity to engage in policy analysis and critique was sharpened, some coercive legislation which was on the anvil was stalled, and partnerships were developed with the media. Some of the problems faced during the campaign included the government's hesitation to engage in interactive dialogue and the deeply entrenched population-control mindset.

One participant expressed his reservation about the successes of 'advocacy from outside' in rural areas, but it was clarified that rural communities can and do engage in independent monitoring. **Community advocacy** for policy and programme initiatives, together with taking on a watchdog role for monitoring their implementation needs to be strengthened, especially by providing communities access to more information. Ms. Indira Jaising elaborated that there were plans for more **collaborative action among women's groups** for a joint presentation on the domestic violence bill with the parliamentarians. There was a concern among the participants regarding the **government appropriating the rights related language without any evidence of corrective action in policies and programmes.** This was clear in a clinical trial on Net-en (a hormonal contraceptive for women) where women were provided neither alternatives nor any information about the contraceptive in question.

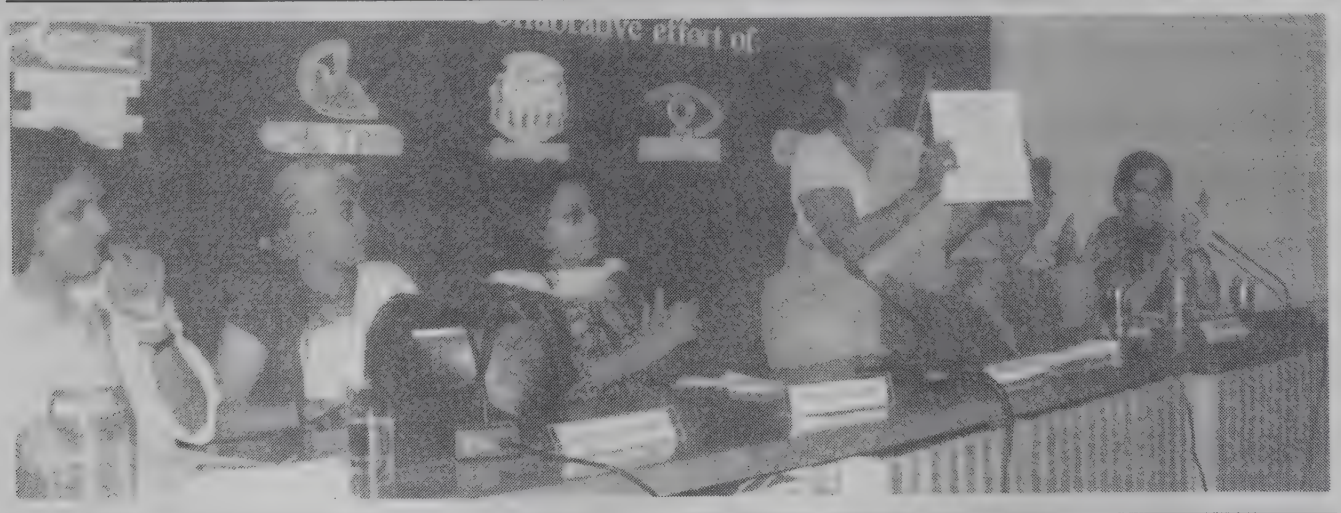
The panelists agreed and one of them shared her experience of how a Minister had told her that the situation of domestic violence in India was 'different' and international definitions did not hold true, and that having a law for domestic violence was based on a 'western' concept.

There were also questions put to the speakers about the **resource constraints** and they were asked whether donors had been forthcoming in funding such activities, especially because the government could not be expected to provide financial support. The panelists clarified it was not just financial resources that were at a premium but motivation and training of persons also, especially lawyers where litigation was concerned. At this point one of the participants shared the **implementers' dilemma** of getting involved in advocacy and monitoring campaigns at one level while also taking grants from the government for managing family planning programmes. Another participant shared her experience where those organizations that engaged in monitoring government programmes from outside, were rarely given funds or invited to participate and contribute in government committees. There was also discussion on the difficulty of implementing laws and policies given the patriarchal mindsets

within communities, but the clear message that came across was that mindsets could not be an excuse for the state for not **ensuring basic human rights.**

Ms. Renu Khanna started her summary by congratulating the panelists for sharing the story of their struggles and campaigns, some of which had been going on for decades. There were very fundamental lessons to be learnt about how advocates needed to form alliances, reflect upon their experiences, evolve new strategies to face new challenges and carry on their work despite limited resources in terms of money, time and people. She also pointed out that there was need to reassess advocacy efforts in today's rapidly changing global scenario, of marketisation and globalization. Civil society is increasingly becoming fragmented. Who would be our new partners, who were the targets of advocacy, who are the adversaries? There were also the contradictory trends, where on the one hand there were some progressive international agreements and national policies, but on the other hand there was collapse of state mechanisms not only in securing justice but also in delivering basic services. There was no way that the government could abdicate its responsibility for delivering basic health services especially where poor disadvantaged and marginalised women were concerned.

The session ended with the release of the report "Priorities of the People- People, Population Policy and Women's Health in Uttar Pradesh" brought out by HealthWatch, UP- Bihar.

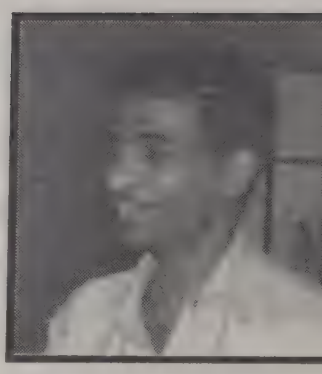


Using Information for Advocacy

Ms. Poonam Muttreja chaired the session and emphasized on the need to attain the right to information by all. She also expressed that accurate information is the basis of advocacy and there is a need for the right information to reach the right person, at the right time.

Ms.Usha Rai shared her experiences of the Media Advocacy Project in which Press Institute of India (PII) is involved in orienting journalists across the country to population and development related issues. She said that unfortunately journalists often considered themselves to be 'know it all', and it was difficult to get them to change their opinions. She related how regional workshops had provided an interesting and informative opportunity for young journalists to understand issues shrouded in misconceptions like family planning, the incidence of domestic violence, gender, sex ratio and the problems of adolescents.

Each state needed a customized approach so that topical issues got covered, but a pool of effective resource persons, including some from NGOs, also contributed to attracting the journalists. Travel Fellowships, a quarterly newsletter that had become very popular, and a Directory of 'Development Journalists' supplemented the workshops. While the process was slow and needed more careful planning, she felt the small group of young and sensitized journalists made the effort worthwhile.



Mr.Sabu George and **Ms. Ila Vakharia** presented some aspects of the campaign against sex pre-selection at the National and State levels. Mr.Sabu expressed his concern that with the kind of sporadic protest the issue got, it would soon disappear from public interest. As it is, the practice of sex pre-selection is in total conformity with cultural norms of devaluing girls and women, and is openly promoted by the refusal of the state to take action against offenders. He suggested the development of state-level campaigns to keep public attention focussed on the issue, as the Public Interest Litigation and Supreme Court Order needed to be supplemented by people's concern. He commented on the role of media as a 'neutral' player, sometimes refusing to take a position on the issue. Only one newspaper, the Times of India from Bangalore had issued an apology on the advertisement appearing in the paper about sex pre-selection, that too after vigilant human rights activists had protested strongly about it.

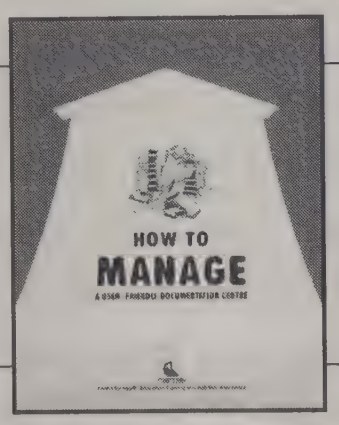
Ms. Ila presented an example of CHETNA's effort to address the issue of declining sex ratio in the state of Gujarat. Strategies included using census data, monitoring popular media programmes and school textbooks, preparing leaflets, reference materials for doctors and press releases for print media. There were also programmes to build NGO capacities to monitor the implementation of the PNDT Act, as well as

carry out community awareness- raising efforts in nine districts using different communication media. The main challenge was a deeply entrenched mindset about women's secondary status, which was effectively supported by religion, the law, police, technology, education system, media and the medical community keen for profit. She recommended a multi-dimensional, multi-level effort across the nation to combat this violation of women's rights, and recommended networking among women's rights, child rights and human rights activists.

Dr.Shubhda Kanani spoke about the need to reorient IEC campaigns. She said the focus of IEC at present is merely the transfer of information and often there are too many confusing and contradictory messages. Experts view people as targets for behaviour change, messaging is gender insensitive and problems and aspirations of people are ignored. Effective IEC was crucial for the success of health interventions. Effective IEC should have focus on empowerment perspective, involve individuals and communities and needs long term efforts. It is more than just an attractive package of audio-visuals, and needs to be context specific and gender sensitive. There must be linkages established between the academic/researcher, the communication person and the field activists if effective IEC has to be designed.

Concluding the session **Ms. Akhila Sivadas** re-emphasised the critical role of information in advocacy. She said that advocates must get their target group to sit and listen to what they had to say- for this one needed to tailor the message according to the group involved. It was very important to work with the media but at the same time mainstream media is not very keen on news about the poor or the rural areas. The regional press is somewhat more open. It is also very important to disseminate information to the masses and one needs to design specific IEC activities. We need to remember that getting new legislation passed is not enough and information has a crucial role in monitoring policy and programme implementation.

At the end of the session a training module on" How to Manage a User-friendly Documentation Centre"- developed by CHETNA was released.



Developing Future Strategies

Three geographical groups depending on the states where they worked were formed. One group was composed of participants from Hindi speaking states of Uttar Pradesh, Bihar, Jharkhand, Uttaranchal and Rajasthan, the second comprised of participants from Maharashtra and Gujarat and the third from among participants from Delhi. Each group took the responsibility of prioritising three or four crucial advocacy issues for the region, key aspects that needed to be advocated for within each issue, identify strategies and stakeholders,

and discuss what kinds of alliances needed to be developed. The groups were also asked to identify areas, which needed to be strengthened for developing partnerships between NGOs. Each group presented its advocacy plan to the plenary, and these plans formed the basis of the recommendations that were presented on the final day of the consultation.

The third day of the consultation focused on presenting the deliberations of the first two days, including the recommendations to government and donor agencies. It was also meant for providing these key players in the arena of women's health and rights a chance to provide their own perspective.

Dr. Kapilashrami, Director, National Institute of Health and Family Welfare chaired the first session of the day. The first presentation was an overview of the proceedings of the last two days presented by Ms. Jashodhara.

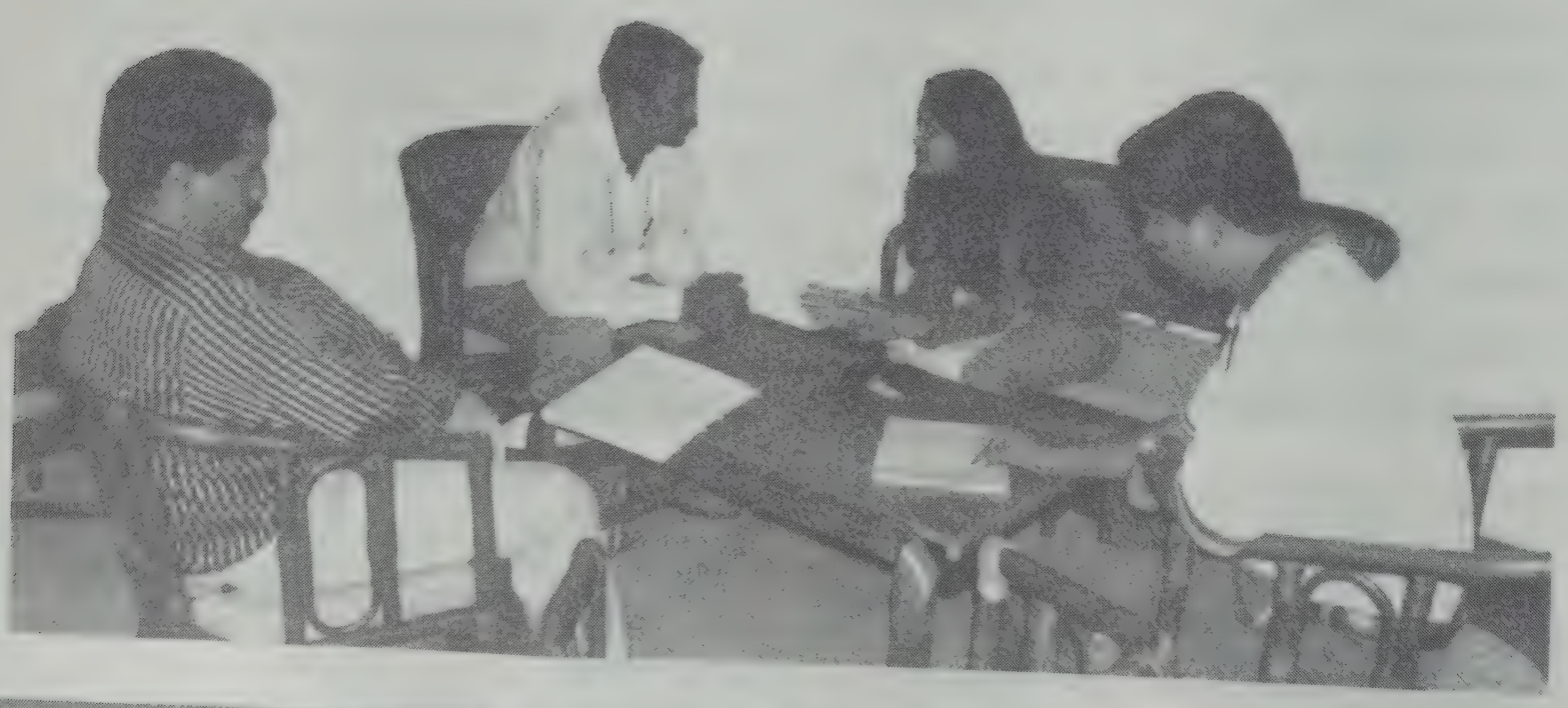
This was followed by presentations of the recommendations emerging out of the previous evening discussions by Mr. Arvind Ojha and Dr. Shubhda Kanani. The Chair reinforced the importance of some of the key issues raised – declining child sex ratio, inadequate implementation of the Community Needs Assessment (CNA) approach, lack of involvement and education of Panchayati Raj Institutions about Reproductive Health, and the need to empower adolescents. This was followed by a discussion in which the participants raised a number of crucial issues.

The crucial importance of the right to information in enabling communities to better monitor and conduct a social audit of health services was highlighted by one participant, especially since the government services are not forthcoming with even the most basic information. Another participant raised the issue of inadequate evaluation of the workload of peripheral workers like the Auxiliary Nurse Midwife before adding responsibilities and new programmes. When this was done it is unrealistic to expect these functionaries to fulfil any of their responsibilities with any degree of competence.

Mr. A.R Nanda emphasized the need to disseminate the important and relevant recommendations to every Member of Parliament and to the Panchayat.

He expressed that the NPP 2000 should have been called the National Social Development Policy...

He suggested that for changing the mindset of population control, there has to be a very sustained preparation, for example, all authorities involved in preparing curricula at every level should be involved in the process. He appealed to the voluntary agencies to refuse funding for activities, which violated the reproductive rights of women. He also warned that often donor agencies come with the hidden agenda of population control. A participant from the flood-affected regions in Bihar raised the issue of area specific, decentralized, need based planning which often gets shortchanged. Another participant emphasized that the ultimate responsibility of ensuring quality basic health services for the poor rests with the government, and at the same time there must be a clearly defined authority to whom such communities could address their grievances. Addressing the role of donors a participant pointed out that their work lacks transparency and accountability to participants, there is little inter-donor coordination and finally their relationship with NGOs is certainly not one of equal and supportive partnership. Another participant reiterated the importance of sensitizing the health fraternity and the law enforcement machinery.



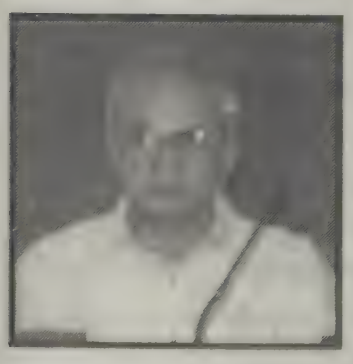
Responses from Government and Donors

Mr. A. R. Nanda chaired this session.

Dr. S.R.Patel, Additional Director Family Welfare, Gujarat presented how the Reproductive and Child Health services had been restored in Gujarat after the earthquake in 2001. He mentioned that the World Bank, WHO, UNFPA, European Commission and UNICEF were supporting them in different aspects of the restoration of RCH services.

Dr. Ashok Bapna, from Harish Chandra Mathur Rajasthan Institute of Public Administration (HCMRIPA), Jaipur and country coordinator of Society for International Development(SID), mentioned the efforts that were ongoing in the social sectors through different technology missions in Rajasthan. He said that the funds of the Government were often not spent, and the training component remained weak. He also highlighted the goals of the Rajasthan Population Policy.

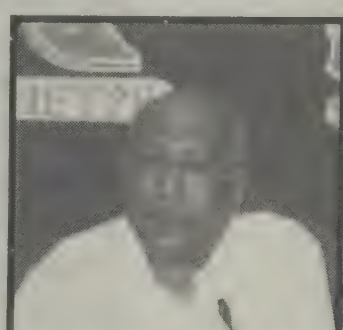
Dr. Jaikaran, Regional Director, Ministry of Health and Family Welfare, UP made a presentation about the situation in UP where there was an attempt to shift to a more holistic approach.



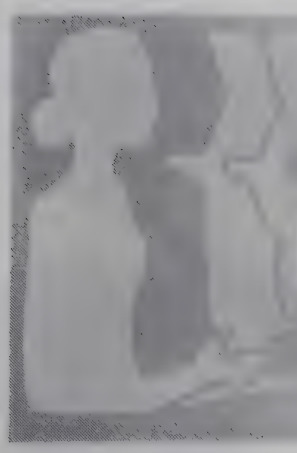
Dr. Kapilashrami, Director NIHFW, shared how his institution being a nodal training institution for RCH, was implementing the training of the RCH programme in collaboration with NGOs, and stated that the constraint was not so much lack of funds but the lack of motivated trainers.

Ms. Yasmin Jhaveri, of Swedish International Development Agency (SIDA), said that the recommendations of the Consultation were extremely timely and important where SIDA was concerned because they were currently involved in preparing their country strategy paper 2003 - 2007. With the overarching goal of poverty alleviation, SIDA has been addressing social development issues and strengthening male involvement, mid-wifery, abortion, adolescent development, HIV/AIDS with the cross cutting imperatives of the rights approach, of gender and democracy. Capacity building is also a major thrust of SIDA. She recommended the inclusion of women's mental health as a critical area of concern.

Dr. Almas Ali representing both the Ministry of Health and Family Welfare and the UNFPA explained that there have been radical changes in the way population is being viewed in India, since 1950s to the present. He said that after independence, the lowered death rate had led to an increased population and the population programmes focused on family planning rather than people's quality of life. The watershed of the ICPD in 1994, led to a shift in the emphasis to people and quality of life. Unfortunately, since much state population policies are not in consonance with the National Population Policy, the GOI has constituted a National Resource Committee to enable states to formulate policies which display a similar concern for well being of the people. He stressed that the innovations done by NGOs need to be incorporated into programme design, and this could go a long way in strengthening partnerships with civil society which was strategic theme of the NPP 2000.



The meeting ended with a vote of thanks to the participants, panelists, speakers and guests who had all contributed in enriching the discussions.



Introduction to organisers, panelists and participants

ORGANISERS

CHETNA: CHETNA is a Non Government Organization based in Ahmedabad, Gujarat whose mission is to contribute towards the empowerment of disadvantaged women, adolescents and children so that they become capable of gaining control over their own, their families' and communities' health. Presently, CHETNA works for education, awareness and empowerment, by supporting and strengthening the work of functionaries of Government and Non-Government Organizations (NGOs), individuals and educators, working to improve the health of women, adolescents and children. CHETNA advocates on concerns/issues critical to health and development of women, adolescents and children through sharing of views, experiences and documents at the state, national and international forums.

SAHAYOG-KRITI : KRITI Resource Centre for Women's Health, Gender and Empowerment is based in Lucknow, Uttar Pradesh. It is a unit of SAHAYOG. It has been established to provide training support, produce and distribute material, engage in creative partnership to strengthen the work of organizations and in turn assist in empowering women at the grass roots level enabling them to lead healthier lives. KRITI is also involved in community based and policy advocacy on women's health and rights, population and reproductive health and violence against women in the states of UP, Bihar, Jharkhand and Uttaranchal, along with the network HealthWatch UP, Bihar. Core values of KRITI Resource Centre include a holistic approach to health, health as a right, life cycle approach, promoting gender sensitive, woman centered and woman controlled health.

HealthWatch : HealthWatch is a national level group of health advocates from diverse fields like training, research, and community organizations. It is a post ICPD initiative to monitor the implementation of platform for action. It is a registered trust based in Delhi. It advocates for comprehensive, gender sensitive women's health policies.

SUPPORT ORGANIZATIONS

ARROW: Asia Pacific Resource and Research Centre for Women – ARROW is a non-governmental, nonprofit organization based in Kuala Lumpur, Malaysia. ARROW advocates to reorient health, population and reproductive health policies and programmes to be more accessible, available and gender sensitive. Priority areas of action for ARROW are: women's rights to comprehensive, accessible, affordable and quality health services throughout their lives, sexual and reproductive health, women centered and gender sensitive health policies and programmes, violence against women. ARROW's priority areas of action are informed by the Beijing Platform for Action.

UNFPA- is the largest internationally funded source of population assistance to developing countries to improve reproductive health and family planning services on the basis of individual choice, and to formulate population policies in support of efforts towards sustainable development.

COORDINATORS OF THE CONSULTATION

Ms. Indu Capoor a Nutritionist and Founder Director of Centre for Health Education, Training and Nutrition Awareness (CHETNA), a support organization whose activities were initiated in 1980. Over the last two decades, CHETNA has gained recognition and credibility as a unique support organization of national importance and international repute. Indu Capoor has conducted and contributed as a resource in about 1000 workshops, training and seminars for government and non-government health and development functionaries. Development of CHETNA as a model support organization,

particularly for effective and widespread health education and communication, has been her significant achievement. She is also the national level coordinator of Women and Health (WAH!) program for management of primary health care programmes. She is also the Co-chair of White Ribbon Alliance for Safe Motherhood-India.She has evaluated several programmes on women, children and adolescents which are being implemented by NGOs, GOs at the state, national and international levels.

Ms. Jyoti Gade is the Programme Officer at CHETNA. Integration of gender component in CHETNA's women's health and development activities is her area of speciality. She has presented several papers related to gender and women's health at various national and international forums. Her major contribution was in writing of the CEDAW alternate document for the Beijing conference and taking the Beijing Platform for Action ahead at the national and state level. She has coordinated and contributed in the Gender Indicator Manual of Reproductive and Child Health Program of India. The manual is for policy makers, programme managers, implementers, and evaluators. She has also been instrumental in developing a gender data bank, gender guidebook and a kit on violence and women's health.

Jashodhara Dasgupta is Founder- Coordinator of SAHAYOG, an NGO working on women's health and rights issues for the last ten years. She is also Founder-Chairperson of AALI, a feminist advocacy NGO working on women's rights in Uttar Pradesh. She has been working at different levels to operationalise the rights approach to women's health, right from the community level in Uttaranchal State to the international level.

She was awarded the MacArthur Fellowship for Population Innovations for three years in 1995. She has been an advocate on women's health issues since post-Cairo and pre-Beijing days at the international level and has been instrumental in setting up a post-Beijing network of women activists in Uttar Pradesh that has carried out considerable monitoring and advocacy activities on rights issues such as Violence Against Women. She is a member of the Steering Committee of the HealthWatch Trust, a national post-Cairo network for advocacy and monitoring. She has also been the convenor for the last six years of a network on Women's Health and Rights called HealthWatch UP-Bihar that is active in monitoring and policy advocacy in the four states of Uttar Pradesh, Bihar, Jharkhand and Uttaranchal. Jashodhara has presented numerous papers on women's health and policies nationally and internationally. She has also been a trainer for gender and women's health for the last twelve years, for various groups ranging from the community level to government medical officers.

SPEAKERS AND PANELISTS

Keynote Speaker

Ms. Rashidah Abdullah: Rashidah Abdullah is the co-founder of ARROW, Malaysia. She has a master's degree in social work and is an expert on women, gender and development for more than a decade. Earlier she was the Manager of the Gender and Development Project of the Asia Pacific Development Centre in Kuala Lumpur, prior to establishing ARROW. She was the head of the Evaluation in Family Planning Section in the Family Planning Federation of Malaysia. She has extensive experience in research and advocacy in the areas of women's reproductive and sexual health and rights and is a member of numerous International expert committees and groups that work on these issues.

PANEL ONE: POLICY ADVOCACY AND MONITORING

Chair-Mr. A. R. Nanda: Mr.A.R.Nanda retired as the Secretary, Family Welfare, and Government of India in the Ministry of Health and Family Welfare in June 2002. He is currently associated with the Population Foundation of India. During his tenure in the Ministry, Mr.Nanda was in the forefront of promoting a health and rights approach in the Family Welfare Programme. He has actively worked with the members of civil society including women's health activists, community based organizations and NGOs to ensure that India remains committed to what was agreed at the ICPD in Cairo. He has been one of the foremost architects of the National Population Policy 2000 and has written extensively on the need to adopt a target free, client centered, quality of care approach to family welfare, which safeguards women's health and rights.

Discussant - Dr. Imrana Qadeer: Dr.Imrana Qadeer is a professor at the Center of Social Medicine and Community Health of the School of Social Sciences, Jawaharlal Nehru University, New Delhi. She has been at the forefront of the Public Health Movement and the Women's Health and Rights movement. She has published numerous writings including research studies and articles in journals and books.

Ms. Meenakshi Dutta Ghosh: Ms Meenakshi Dutta Ghosh was the former Joint Secretary in the Ministry of Health and Family Welfare and is also Project Director of the National Aids Control Organization. Till July 2002, Ms. Ghosh was Joint Secretary (Policy) in the Department of Family Welfare and in that capacity was involved in operationalising the National Population Policy 2000.

Dr. Vimala Ramachandran: Dr Vimala Ramachandran is an eminent researcher and activist who has been working for many years on issues such as women's education, health and rights. She is one of the founder members of the national advocacy group HealthWatch, and is well known for her pioneering work with Mahila Samakhya Society project. Ms. Ramachandran writes extensively on different development related issues.

Dr. Mohan Rao: Dr. Mohan Rao teaches at the Centre of Social Medicine and Community Health at the School of Social Sciences, Jawaharlal Nehru University. He has been at the fore front of the movement to mainstream the rights perspective in the population and public health policy arena and has been actively associated with the monitoring of the Alma Ata declaration through the People's Health Assembly (PHA). He has written extensively on the subject including books, research studies, articles and journals.

Dr. Sarala Gopalan: Dr Gopalan is currently a free-lance researcher on women's empowerment and development related issues. Ms. Gopalan retired as the Secretary in the Minsitry of Human Resources Development , Government of India in the Department of Women and Child Development. She has been recently instrumental in editing two profiles on women's health and development, one as a joint WHO-Voluntary Health Association of India publication and the other for the National Commission on Women.

Dr. Badri Saxena: Dr. Badri Saxena presently holds a position of Emeritus Medical Scientist to Indian Council of Medical Research and Research Professor at Center for Policy Research, New Delhi. He has received more than 15 national and international awards. He has published over 150 scientific, technical papers in national and international journals. He has a rich research experience in the area of reproductive health, family planning, maternal and child health, safe abortion services, RTIs/STDs, and nutrition.

PANEL TWO-INITIATIVES IN SAFE MOTHERHOOD

Chair - Dr. H. Sudarshan: Dr. Sudarshan is a medical doctor with more than two decades of experience of working in remote, tribal areas of Mysore district. He is known for his devotion to serve humankind, particularly the most needy. Through the Vivekanand Girijan Kalyan Kendra and Karuna Trust he has done outstanding work in primary health care. Several awards including the Padmashree and the Right Livelihood Award have honored him. He was the Chairperson on the Task Force on Health in the state of Karnataka and is currently the Vigilance Commissioner in Health for the Lok Ayukt in Karnataka.

Discussant - Dr. Shyam Ashtekar - Dr. Shyam Ashtekar is a medical doctor with post graduate specialization in Preventive and Social Medicine. He is the founder of Bharat Vaidyak Sansthan in Nasik, Maharashtra State. He has special interest in training paramedical workers and preparing training modules for health workers, health system and health policy research. He was awarded the Fellowship for Population Innovation from Mac Arthur Foundation during 1997-2000. He has published numerous books, the recent being health and healing manual for primary health care. He is an active member of Medico Friend Circle and coordinates the activity of the PHC Cell.

Mrs. Bhattacharya: Mrs Bhattacharya is a trained nurse and midwife and is the current Secretary of the Society of Community Midwives, India.

Ms. Uma Handa: Ms. Uma Handa has done M.Sc. in Nursing with gold medal with specialization in

Obstetrics, Neonatology and Gynaecology. She is a consultant Midwife, UNICEF- Health/ICO (SM). She is a consultant to many countries for developing B.Sc. nursing programmes- Sri Lanka, Bangladesh, Nepal and Namibia. She is a consultant to National Open School on preparing curriculum course material for health related, paramedical course and developing strategy for implementation. She is the first nurse to be honored as Hall of Fame by the Nursing Honours Society of India.

Dr. Pankaj Shah: Dr. Pankaj Shah is a community health physician working with SEWA- Rural, Jhagadia, Gujarat, since its inception. Dr. Shah played a key role in creating a successful model of NGO-GO collaboration in running a government Primary Health Centre, the first of its kind in India. He is a Fulbright Fellow. He is one of the trustees of SEWA- Rural and is currently the hospital administrator of the First Referral Unit pioneered by SEWA- Rural.

Vd. Smita Bajpai- Vd. Smita Bajpai is currently involved with CHETNA's Women's Health and Resource Center. She is a trained Ayurvedic Doctor and a pioneer for advocating traditional health and healing. She has actively contributed to different national efforts to promote traditional healing practices related to gynaecology. She is actively coordinating the safe motherhood campaign in Rajasthan state, India. She advocates for safe motherhood, with the Dai as an available, affordable, accessible resource for safe birth at home

Ms. Aparjita Gogoi: Ms. Aprajita Gogoi-is a communication and advocacy officer, CEDPA-India and Coordinator of the White Ribbon Alliance for Safe Motherhood-India. She is a PhD. in International Politics and also has a post graduate diploma in Journalism. Her areas of expertise include communication and advocacy, formulating and implementing communication and advocacy programs and strategies, designing of behavior change communication campaigns and training in communication programs.

Dr. P Biswal: Dr. P Biswal is a Deputy Director in the Ministry of Health and Family Welfare and is involved in the implementation of the Reproductive and Child Health Programme.

PANEL THREE-ADVOCACY FOR CHANGE IN PROGRAMME IMPLEMENTATION FOR NEW RH ISSUES

Chair-Dr. Sharada Jain: Dr. Sharada Jain is an educationist and researcher by profession. She was Coordinator of the Women's Studies unit of Rajasthan University for seven years and is Coordinator of SANDHAN since 1993. SANDHAN conducts research on women's issues, women's empowerment and development. She is a member of various reputed networks and advisory committees such as ICSSR, and National Council for Teacher's Education.

Discussant-Dr M Prakshamma: Dr. M Prakasamma is a Nurse, Midwife, public health and gender researcher. She is Director, Academy for Nursing Studies, Hyderabad, and editor of two journals for women grassroots workers, midwives and nurses. She has been engaged in upgrading standards of female health workers for the last 20 years. She has worked as a gender consultant at WHO and helped in launching initiatives for mainstreaming gender in health.

Ms. Firoza Mehrotra: Ms. Firoza Mehrotra is an IAS Officer of Haryana Cadre with more than two decades of experience of working at the field level as well as at the policy level. She has worked extensively on gender issues, women's empowerment, adolescent and population development concerns. She is presently an advisor in the Planning Commission of the Government of India.

Dr.K Pappu: Dr. K.Pappu is Officiating Director of Child in Need Institute (CINI), Calcutta. A medical doctor by profession, he has done his masters in Community Health from Liverpool School of Tropical Medicine. He is also involved in providing leadership to CINI –Asha whose mission is to improve the quality of life of children. Along with children's and adolescent issue he has made special efforts for effective implementation of TB control program.

Ms. Pallavi Patel: Ms. Pallavi Patel is coordinating the activities of the Women's Health and Development Resource Centre of CHETNA in Ahmedabad. She is a trained nutritionist with wide ranging experience in

training, research and communication on comprehensive women's health.

Ms. B. Bhamathi : Ms. Bhamathi, an IAS officer of the Bihar Cadre has extensive experience in working on women's issues. She is currently working as the Technical Adviser on Gender in the United Nations Population Fund(UNFPA), India Office and is involved in a large number of efforts to sensitize health care providers and programme managers of Reproductive Health services in gender. This is part of UNFPA's interventions in the seven states of Haryana, Rajasthan, Gujarat, Madhya Pradesh, Maharashtra, Orissa and Kerala, as well as with the MoHFW, GOI.

Ms. Renu Khanna and Dr. Usha Ubale: Ms. Renu Khanna and Dr. Usha Ubale are working in a collaborative project called the Women's Centred Health Project in the Brihanmumbai Municipal Corporation (BMC, Mumbai). Ms. Khanna represents an NGO, SAHAJ in coordinating the project while Dr. Usha Ubale who is a Health Officer with the BMC is the Project Coordinator.

Dr. Seema Malik and Ms. Padma Deosthali : Dr. Seema Mullick is by profession a gynaecologist and has a diploma in hospital administration. She has also done a course on medico-legal system. She was incharge of Municipal Maternity Hospital for three years and is presently working as a medical superintendent of K.B.Bhabha Hospital, Mumbai. She has obtained fellowship award on women and development from Institute for Social Studies, Netherlands. Ms. Deosthali represents NGO, CEHAT in the collaborative project DILAASA – a one stop Violence Crisis Centre, at the Bhabha Hospital.

Ms. Sunita Kujur- Ms. Sunita Kujur is a social worker trained at the Delhi University. She has been working on issues of sexuality and sexual and reproductive health with TARSHI (Talking about Reproductive and Sexual Health in India) for over five years. She has been a counsellor on the TARSHI helpline for three years and has conducted sessions on sex education in schools and colleges. She has also been involved in bringing out publications for young people.

PANEL FOUR-ADVOCACY FROM OUTSIDE THE SYSTEM

Chair - Ms. Nirmala Buch : Ms. Buch retired as the Chief Secretary to the Government of Madhya Pradesh. She was earlier Secretary, Rural Development to the Government of India. She is now the Chairperson of the Mahila Chetna Manch in Bhopal and works as an independent researcher and advocate on issues related to women's empowerment, women's health, rural development and Panchayat Raj. She has recently completed a multi-state study on the impact of the two-child norm in Panchayat on women's empowerment.

Discussant - Ms. Renu Khanna: Ms. Renu Khanna has a management background. She began her career with VHAI and is a well-known health activist. She is a founder member of SAHAJ- Society for Alternatives in Health, and is also involved with the Women's Health Training and Research Centre in the MS University Vadodara, Medico Friends Circle, SARTHI, and PUCL, Vadodra. She is an accomplished programme manager, trainer, researcher and advocate. She is deeply concerned with women's right to health in the contemporary context.

Ms. Vani: Ms. Vani has been involved with the women's health movement. She is associated with SAHELI, a women's organization. SAHELI has been involved with the campaign against hazardous contraceptives and the population policy and its implications for women's health for over two decades.

Ms. Sumita Menon: Ms. Menon is from the Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai. She is a graduate from TISS and has been working with CEHAT on issues related to the private sector in health, domestic violence and human rights.

Adv. Indira Jaisingh: Ms. Indira Jaisingh started her career as a lawyer in early sixties and in 1986 was designated a senior advocate by the High Court of Bombay, which was unprecedented. She is known for her work on human rights, rights of women and poor working class. She has worked

on very significant cases like that of sexual harassment, compensation for the Bhopal Gas tragedy victims, sex-selection etc. Ms. Indira Jaisingh is founder secretary of the Lawyer's Collective and is its current Director. She is currently engaged in advocacy for a law on domestic violence.

PANEL FIVE - USING INFORMATION FOR ADVOCACY

Chair- Ms Poonam Muttreja : Ms Poonam Muttreja is currently country co-ordinator of the MacArthur Foundation (India Office) and has a long background of activism in India especially around issues of rights, health and livelihoods. She has been instrumental in setting up and managing Fellowship in Population Innovation and the Leadership Fellowship programme of the Foundation in India that has supported innovative approaches to sexual and reproductive health and rights.

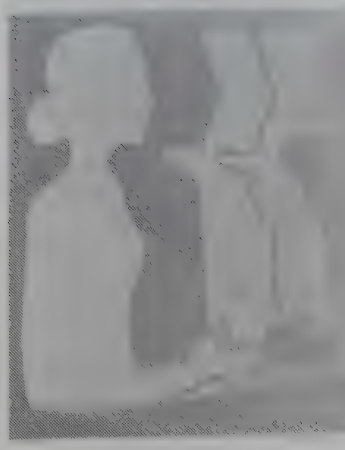
Discussant- Ms. Akhila Sivadas : Ms. Akhila Sivadas is a founder-director of Centre for Advocacy and Research. She is involved in assisting various academic and action research projects, and is also a free lance journalist on issues related to women and media. She is also a media consultant to UN AIDS. She was awarded the Mac Arthur fellowship in Population Innovations and developed a module on conducting Advocacy on Reproductive Health.

Ms. Usha Rai: Ms. Usha Rai is a very senior newspaper journalist and Deputy Director of the Press Institute of India(PII), which is a non-profit media organisation devoted to developing quality journalism. Ms Rai heads a media advocacy project in PII on Population, Development and Gender issues within the media which is in collaboration with MoHFW and UNFPA.

Dr. Sabu George : Dr. Sabu George has been a crusader against female infanticide and foeticide in the country . He has been involved in filing the Public Interest Litigation in the Supreme Court against the poor implementation of the Prenatal Diagnostic Act (1996), and has been involved in the follow up on the Court's directives in different states.

Ms. Ila Vakharia: Ms. Ila Vakharia is a Programme Officer in the Child Resource Centre of CHETNA . She is a sociologist by training and has more that one and half decades of experience in capacity building training, and developing communication materials. She is presently coordinating the Mother NGO project at CHETNA.

Dr. Shubhda Kanani: Dr. Kanani is a reader in the department of Food and Nutrition at M.S. University and Founder Director of AROGYA at Vadodara. She has researched and written extensively on nutrition and health. She has recieved awards from Nutrition Society of India, Indian Dietetics Association, National Institute of Health and Family Welfare



ANNEXURE - I

Programme Schedule

26-06-2002 (Day One)

10.30 a.m. Objectives and Introduction:

Ms.Indu Capoor, Founder Director, CHETNA

11.30 a.m. Framework of Advocacy for Women's Health & Rights:

Ms. Rashidah Abdullah, ARROW, Malaysia

12.00 - 1.30 p.m. Panel One-Policy Advocacy and Monitoring

Chair- Mr. A. R. Nanda Discussant - Dr. Imrana Qadeer

- Panel-Dr. Vimala Ramachandran: HealthWatch : On the Paradigm Shift in Indian Population Policies
- Dr. Mohan Rao: PHA; the National Health Policy
- Ms. Meenakshi Dutta Ghosh, National Population Policy
- Dr. Sarala Gopalan: National Policy for the Empowerment of Women
- Dr. Badri Saxena: Need for Monitoring Indicators: National Population Policy
- Release of Kit - Women's Health and Rights: Briefing sheets for Advocacy by SAHAYOG
- 1.30-2.30 p.m. Lunch

2.30 - 4.00 p.m. Panel Two-Initiatives in Safe Motherhood

Chair-Dr. Sudarshan Discussant-Dr. Shyam Ashtekar

- Panel - Mrs. Bhattacharya : Society for Community Midwives
- Ms. Uma Handa: Concept of Community Midwife
- Dr. Pankaj Shah-Sewa Rural, Jhagadia: Making of a FRU at Sewa Rural, Jhagadia
- Vd. Smita Bajpai-CHETNA: Safe Motherhood at Home, TBA approach
- Ms. Aparjita Gogoi: WRAI Campaign on Safe Motherhood
- Dr. Biswal, Dy. Director (MoHFW): New Initiatives of the Government

4.00 - 6.00 p.m. Panel Three-Advocacy for Change in Programme Implementation - New RH Issues

Chair-Dr. Sharda Jain Discussant-Dr M Prakshamma

- Release of Book: Empowering Adolescent, Learning for Life
- Panel: Ms. Firoza Mehrotra: Adolescent Empowerment: Issues and Challenges
- CINI (Dr. Pappu), CHETNA (Ms. Pallavi Patel): Mainstreaming of work with adolescents
- Ms. Bhamathi - UNFPA: Mainstreaming of Gender in population and RH programmes.
- Ms. Renu Khanna and Dr. Usha Ubale: BMC experience with RTI/STDs
- Dr. Seema Malik and Ms. Padma Deosthali-CEHAT: Mainstreaming VAW in Primary Health Care
- Ms. Sunita Kujur-TARSHI:Sexual Health Advocacy

27/06/02 (Day Two)

9.00 a.m. - Panel Four-Advocacy from outside the system

Chair- Ms.Nirmala Buch, Discussant - Ms. Renu Khanna

- Ms. Vani, Saheli-Campaigns against Hazardous Contraceptives
- Ms. Sumita Menon: CEHAT: PIL in the Supreme Court against Sex Pre selection
- Adv. Indira Jaisingh: Lawyers Collective Bill on Domestic violence
- Ms. Jashodhara: UP Population Policy Advocacy

- 10:30 a.m. Tea

Release of Report: Priorities of the people: People,Population Policies and Women's Health in Uttar Pradesh

11:00 a.m. - 12.30 p.m. Panel Five- Using Information For Advocacy

Chair- Ms. Poonam Muttreja Discussant- Ms. Akhila Sivadas

- Ms. Usha Rai: Media Advocacy for RH
- Mr. Sabu George : Proposed Amendments to the PNDT Act
- Ms. Ila Vakharia: Crusade against Female Foeticide
- Dr. Shubhda Kanani: Advocating for a Paradigm Shift for Health Communication.
- 12:30-1:30p.m. Lunch

Release of Book: Manual on how to Manage IDC

1:30 p.m. - 6.00 p.m. Group work: Future Strategies and Stakeholders Roles/Partnerships

- Facilitator: Dr. Abhijit Das, SAHAYOG
- Tea
- Presentation in plenary
- Preparation for presentation on 28/6/02

28/6/02 (Day Three)

10:00 a.m. - 12.00 noon Valedictory Session

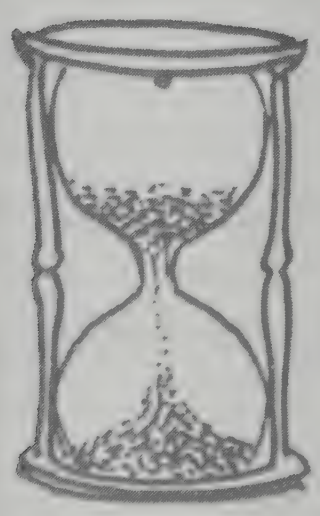
- Inauguration
- Overview of processes so far-Ms. Jashodhara, SAHAYOG
- Overview of the two days
- Presentation of key recommendations - Arvind Ojha; Urmul Trust and Dr. Shubhada Kanani, AROGYA

12:00 noon - 2.00 p.m. Responses from the Government

- Chair: Mr A.R. Nanda
- Dr. Kapilashrami, Director, National Institute of Health and Family Welfare, New Delhi
- Dr. Ashok Bapna, Professor in Economics, The HCM Rajasthan State Institute of Public Administration, Rajasthan
- Dr. S.R.Patel. State Programme Officer, IPD, Gujarat
- Dr. Jaikaran, Regional Director, Ministry of Health and Family Welfare, Uttar Pradesh

Responses from Donor agencies

- Dr. Almas Ali – MoHFW and UNFPA
- Ms. Yasmin Jhaveri -Swedish International Development Agency (SIDA)
- 2.00-Vote of thanks and wind up
- Lunch



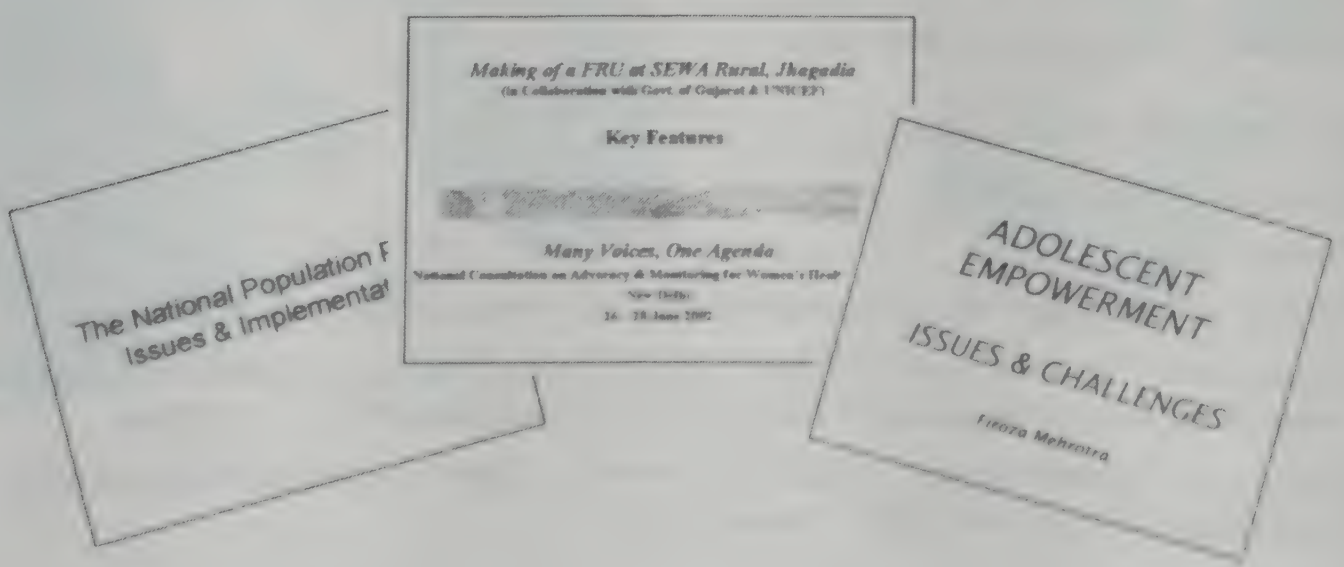
ANNEXURE-II

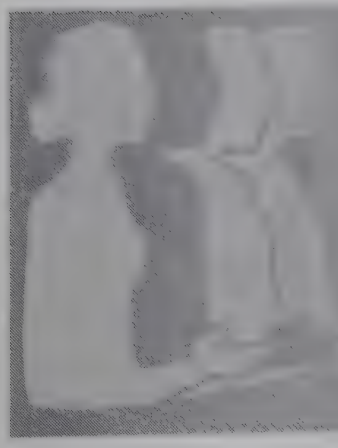
List of papers presented and distributed during the National Consultation on Advocacy and Monitoring for Women's Health and Rights: 26-28 June 2002, India International Centre, New Delhi

SR. NO.	TITLE	AUTHORS
1.	Framework of Advocacy for Women's Health and Rights	Ms Rashidah Abdullah Director - ARROW Kuala Lumpur - Malaysia
2	Concept paper on Community Midwife	Ms. Uma Handa UNICEF - New Delhi
3.	Making of a FRU at SEWA Rural, Jhagadia	Dr. Pankaj Shah SEWA-Rural Jhagadia - Bharuch
4.	Advocating for Safe Motherhood at Home The Dai (Traditional Midwife, TBA) Approach	Vd. Smita Bajpai Coordinator (THHP) WHDRC- CHETNA
5.	Adolescent Empowerment: Issues and Challenges	Ms. Firoza Mehrotra Adviser (Admn.) Planning Commission New Delhi
6.	Riding into the future	Ms Pallavi Patel Deputy Director - WHDRC - CHETNA
7.	Advocacy for RTI Services within BMC	Ms. Renu Khanna and Ms. Usha Ubale SAHAJ - Vadodara and BMC
8.	Bringing together Collaborative Partners	CEHAT, BMC - Mumbai Dilasa Project
9	Campaign for a Civil Law on Domestic Violence	Ms. Indira Jaisingh Lawyers' Collective Mumbai
10	Public Interest Litigation on PNDT act - 1994	Dr. Sabu George CEHAT - Mumbai
11	Crusade against Female Foeticide	Ms. Ila Vakharia Programme Officer CRC - CHETNA
12	Many Voices, One Agenda-overview and Recommendations	SAHAYOG - Lucknow
13	Initiatives at State Level	Mr. S R Patel State Programme Officer ICPD Project Gandhinagar

Articles distributed during the conference:

SR. NO.	TITLE	AUTHORS
14	Global Distribution of Income	Not Available
15	A Frame for Advocacy	Population Council
16	Population Policy and Women's Empowerment	Ms.Carmen Barroso
17	Empowering Women for Reproductive Rights	Ms. Gita Sen
18	Organizing Delivery Care: What works for Safe Motherhood	M. A. Koblisky
19	A Brief Report of Sub-Group on Programmes for Adolescents	Govt. of India
20	Contraceptive Methods for Women	Text book - Biology XII
21	Advocacy for Action:CHETNA's Experience	CHETNA
22	Gender Mainstreaming: CHETNA's Experience	Ms. Jyoti Gade
23	Screening IEC Material from Gender Lens	Ms. Pallavi Patel / Ms. Indu Capoor
24	Transforming Family Planning Services in the Latin America and Caribbean Region	Judith Helzner
25	White Ribbon Alliance India Media Kit	WRAI
26.	Safe Motherhood at Home A case presentation by CHETNA	CHETNA





ANNEXURE- III

List of materials distributed during the National Consultation on Advocacy and Monitoring for Women's Health and Rights: 26-28 June 2002, India International Centre, New Delhi.

ARROW Publications

1. Health Resource Kit: Gender and Women's Health.
2. A frame work of Indicators after Beijing
3. Taking up the Challenges
4. In Dialogue for Women's Health Rights
5. ARROWs for Change- Newsletter

CHETNA Publications

1. Counselling Cards on Child Health
2. Adolescent Health and Development- Perspective paper
3. Empowering Adolescents - Learning for life (Adolescent Module)
4. Life Useful Materials on Adolescents with Child Birth Picture Book
5. Women and Health Pamphlets
6. Women's Health Towards Empowerment
7. Anaemia Kit - English and Hindi
8. Breast Cancer (English)
9. WAH! Curriculum Report
10. WAH! Approach Documents
11. Healing with Herbs
12. Gender Indicators Manual
13. International Women's Day - 2002 : Poster
14. How to Manage a User- friendly Documentation Centre (IDC Manual)
15. CHETNA Activity Report. 2000 - 2001

SAHAYOG-Kriti Publications

1. Swasthya - Sakhi (Hindi)
2. Swasthya - Prahari (Hindi)
3. Priorities of the People: People,Population Policy and Women's Health in Uttar Pradesh
4. Briefing Sheets for Advocacy on Women's Health and Rights(Hindi): National and International commitments of the Government of India, SAHAYOG and HealthWatch - UP, Bihar
5. News Letter: Swasthya Prahari-Advoacy for Women's Health and Rights Brochures about HealthWatch UP-Bihar and KRITI Resource Centre

UNFPA Publications

1. Module on three-day training of Primary Health Centre Medical Officers on Gender and RH with Facilitator's Manual
2. One-day Gender Training Module on RH for Female Health Workers
3. One-day Training Module of Primary Health Centre Medical Officers on Gender and RH with Facilitator's Manual
4. Gender and Reproductive Rights in India: Problems and Prospects for the New Millennium.

List of other Publications distributed

1 A Report: Workshop on Population Problems: New Horizons and Challenges- Govt.of Rajasthan

2 Rationalizing New Population Policy: Suggested Strategies- CFPR

3. UNDP Human Development Report - 2001 (an Assessment)- CHSD

4 Women in India - How free? How equal?- A UN Publication

5. Towards Equality - The Unfinished Agenda - Status of Women in India - 2001- NCW

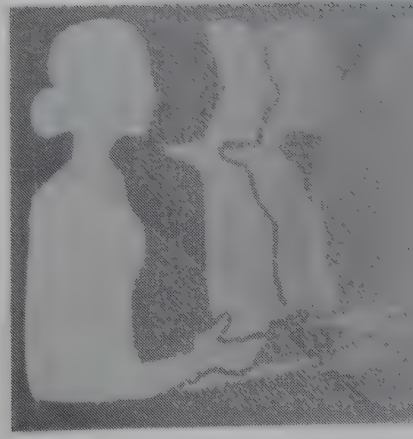
6 Report of Workshop on Empowerment of Women with Special Reference to Women's Health- NCW

7. NGO Newsletter Sampark- NIPCCD

8. Stri Sashaktikaran (Hindi)- NIPCCD

9. Sabala (Hindi)-JAGORI

10. Issue of Seminar (March 2002)- Malvika Singh



Annexure - IV

List of Participants - New Delhi

Sr. No.	Name	Organization
1	Ms. Geetanjli Goel	Human Rights Law Network
2	Ms. Shruti Pandey	65, Masjid Road, Jangpura, New Delhi - 110 014 Tel : 4316922
3	Mr. Rumman Hameed	Consultant, Voluntary Action Cell (VAC) Planning Commission, Yojana Bhavan, Sansad Marg, New Delhi - 110 001 Tel : 011-3715481, Extn. : 2315 Email : rummanhameed@yahoo.com
4	Ms. Janet Chawla	120, Sundernagar, New Delhi - 110 003 Tel : 011-4351190, 4351821, Email : janchawla@hotmail.com
5	Ms. Sudha Tiwari	Parivar Seva Sanstha
6	Ms. Jharna Mehapatra	28 Defence Colony Market, New Delhi-110024 Tel : 4611829, 4619024
7	Ms. Seema Srivastava	Jagori. C-54, South Ex. II, New Delhi - 110 049. Tel : 6257015 / 6253629 Email : jagori@dd3.vsnl.net.in
8	Ms. Prachy Mishra	Lawyers' Collective - Women Rights Initiative
9	Ms. Sujan	63/2, Nassid Road
10	Ms. Maylbi	Jaipuria, New Delhi Tel : 011-4316925, 4321101 Email : wri@vsnl.net
11	Ms. Shveta Kalyanwala	HealthWatch, 4A6 Sahvikas 68, 11 Extension, Delhi - 110092 Ph : 3367110, Fax : 2429749
12	Mr. B. Bhattacharya	RAK College of Nursing Opp. Lajpat Bhawan Lajpat Nagar, New Delhi - 110 024. Tel : 643779
13.	Ms. Meenakshi Dutta Ghosh	NACO (National AIDS Control Organization) Ministry of Health and Family Welfare Chandralok Building, 3rd Floor, Janpath New Delhi - 110 001 Tel : 011-6116427(R)
14.	Dr. Sarala Gopalan	138, Vasant Enclave, New Delhi - 110 057 Tel : 011-6151065

Sr. No.	Name	Organization
15.	Mr. M.I. Khan	New Delhi
16.	Dr.P.K. Goswami	Director MAMTA, 33 A Saidulaja, M.B. Road, New Delhi - 110 030 Tel : 6858067 Fax : 6525466
17.	Ms. Vineeta	SAHELI
18.	Ms. Vani	Women's Resource Unit Defence Colony, Flyover Market New Delhi - 110 034 Tel : 011-4616485 Email : saheliwomen@hotmail.com
19.	Ms. Ritu Massey	PATH Finder G-42 Jungpura Ext. New Delhi - 110 014 Tel : 4316815, 4316816 Fax : 4318153
20.	Dr. Almas Ali	UNFPA (United Nations Population Fund) MOHFW
21.	Dr. Kiran Sharma (Consultant)	
22.	Dr. P. Biswal (Asst. Commission)	55 Lodi Estate New Delhi - 110003 Tel : 011-4628877 (Extn. 372)/464138, 3010640
23.	Ms. T.V. Padma	Panos Institute , 49 1st floor, Defence Colony Market, New Delhi - 110 024 Tel : 011 - 4631351
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Annexure - V

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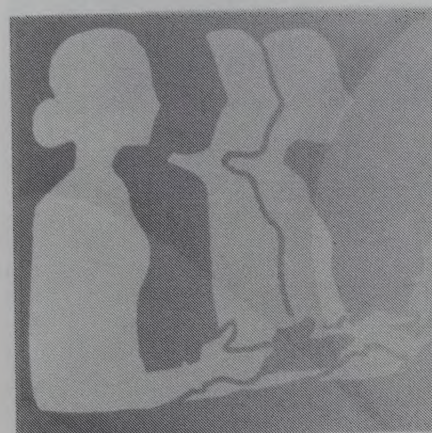

ANNEXURE- VI

Media Coverage

गरीब महिलाओं को स्वास्थ्य का अधिकार दिये बिना विकास संभव नहीं

विशेष संवाददाता

नई दिल्ली, 27 जून। गरीब महिलाओं को स्वास्थ्य का अधिकार दिये बिना देश का विकास सम्भव नहीं है। यह राय यहां चल रहे महिलाओं के तीन दिन के सम्मेलन में उभर कर आई है। महिलाओं के स्वास्थ्य और अधिकारों के बारे में राष्ट्रीय परामर्श में भाग लेने वाली महिलाओं ने अपने अनुभवों का उल्लेख करते हुए मत व्यक्त किया कि जहां 65 प्रतिशत महिलाओं को बच्चों को जन्म देते समय चिकित्सा नहीं मिल पाती है और हर पांच मिनट में किसी जच्चा की मौत भी हो जाती है उस देश में महिलाओं के स्वास्थ्य और उनके अधिकारों की किसी भी हालत में अनदेखी कैसे की जा सकती है?

अपने प्रारम्भिक सम्बोधन में अहमदाबाद के स्वैच्छिक संगठन चेतना की निदेशक इन्दु कपूर ने कहा कि महिलाओं के स्वास्थ्य के मुद्दे को बढ़ावा देने और इस बारे में पूरी निगरानी रखने की आवश्यकता है। उन्होंने कहा कि नई प्रगतिशील नीतियों के बावजूद महिलाओं को स्वास्थ्य सुविधाएं नहीं मिल पाती हैं।

सम्मेलन के बीज भाषण में महिला स्वास्थ्य की जानी - मानी अनुसंधानकर्त्ता मलयेशिया की रशीदा अब्दुल्ला ने कहा कि भारत की महिलाओं के स्वयंसेवी संगठनों ने महिलाओं के स्वास्थ्य के मुद्दों को विश्व मंच पर प्रस्तुत किया है। उन्होंने कहा कि भारत ऐसा पहला देश है जिसने काहिरा व पेइचिंग के एजेंडे को उपयुक्त स्थान दिया है। भारत के पूर्व परिवार कल्याण सचिव श्री ए.आर. नन्दा ने कहा कि महिलाओं के अधिकार मानवाधिकारों के अविभाज्य अंग हैं। उन्होंने कहा कि वर्तमान जनसंख्या नीति में महिला सशक्तीकरण की बात की गई है परन्तु अभी उनके जीवन स्तर में परिवर्तन होना बाकी है।

हेल्तवाच से सम्बद्ध अनुसंधानकर्त्ता विमला रामचन्द्रन जनसंख्या नियंत्रण के लिए नए सिरे से किये जा रहे प्रयासों की आलोचना की और कहा कि ऐसे प्रयास विकास विरोधी होने के साथ ही महिला विरोधी व जन विरोधी हैं। भारत सरकार महिला व बाल विकास की पूर्व सचिव डा. सरला गोपालन ने कहा कि समूची सोच और सांस्कृतिक दृष्टि में बदलाव लाने की जरूरत है क्योंकि इससे न केवल महिलाओं के बारे में समुदाय के नजरिये में बदलाव आता है वरन् सेवा प्रदाताओं के नजरिये में भी बदलाव आता है।

भारतीय चिकित्सा अनुसंधान परिषद के पूर्व शोधकर्त्ता डा. बद्री सक्सेना ने स्वास्थ्य से जुड़े मामलों की निगरानी में स्थानीय समुदायों की भूमिका को रेखांकित किया।

Women's health status still poor

NEW DELHI (UNI): Policy-makers, academicians and health care advocates on Wednesday expressed concern over continuing poor status of women's health in India, despite recent announcements by the Government on a gender and rights-based approach in health and population policies.

The reverse sex ratio of 933 women per 1000 men as revealed by the Census Report 2001, rowing misuse of the Pre-Natal Diagnostic Techpique (PNDT) to abort a female foetus, high rates of infant and maternal deaths and severe anemia in over half of all married women in India are just some of the indicators of the low priority accorded to women's health in he country.

Initiating a National Consultation on Advocacy and Monitoring for Women's Health and Rights in the capital, former Union Secretary for Family Welfare A R Nanda stressed the need to adopt a target-free, client-centred, quality of care approach to family welfare which safeguards women's health and rights.

Ms Meenakshi Dutta Ghosh of the National AIDS Control Organisation (NACO) giving an overview of the National Health policy said the Government is examining alternate format in reproductive health care services to determine local needs. "We want communities at the grassroots to articulate their needs and problems", she stressed.

Dr Sarla Gopalan cautioned that the National Policy for the Empowerment of Women would remain just a laudable document unless certain basic issues were addressed such as access to services, service environment, client-provider interaction, equipment and supplies, continuity of care, integration of services and women's participation in decision-making.

The three-day Consultation being attended by about 100 representatives from ten States representing women NGOs, government organisations and research and funding organisations has been organised jointly by Ahmedabad-based NGO CHETNA, Sahayog/Kriti Resource Centre, Lucknow, Health Watch, New Delhi and Arrow of Malaysia.

Dr Badri Saxena of the National Population Policy Centre for Policy Research, an autonomous body under the Ministry of Health and Family Welfare, spoke on the limitations of the current monitoring system in the National Population Policy (NPP) 2002.

He said the existing system does not adequately integrate information from different sectors or accurately reflect local needs and requirements. Sadly, local ownership of the reproductive health care programme has been missing because of inadequate utilisation of locally available manpower, he pointed out.

Dr Saxena said the immediate objective of NPP 2002 is to reduce unmet need of contraception, involvement of NGOs in rural/urban slums and remote areas, strengthening infrastructure and appointment of women medical and paramedical health functionaries.

Dr Imrana Qadeer, professor at the Centre of Social Medicine and Community Health of the School of Social Sciences, Jawaharlal Nehru University, said women's health is linked with the polities and economy of the country.

She alleged that the entire health sector is being transformed from a non-profit sector to one which is anti-poor and a prolific industry. "We have become guinea pigs to multinationals which are coming in through the government. When you talk of advocacy you have to address these issues, we have a right to know what is happening within the Ministries", she said.

On the occasion, Mr Nanda released a set of documents in Hindi entitled: "Women's Health and Rights: Briefing Sheets for Social Advocacy—Policies and International Declarations of the Government of India". The Briefing Sheets have been prepared by KRITI Resource Centre, a unit of SAHAYOG which is working on women's health and rights.

'Not much has been done for rural women'

CHECKING IN

"Women's health is a human rights issue; the state should be made accountable for it"

Malaysian women's rights activist Rashidah Abdullah on women in India and Malaysia

SURABHI JAIN
NEW DELHI, JUNE 27

RASHIDAH Abdullah, the co-founder of the Malaysia-based NGO Asia-Pacific Resource and Research Centre (ARROW), has been actively involved with women's development and other related issues.

She was the head of the Evaluation in Family Planning Section in the Family Planning Federation of Malaysia. Rashidah firmly believes that NGOs should be allowed to be a part of the policy making set up. She spoke to *Newsline* about women, India and gender issues.

Women's health: a human rights issue

ARROW recently conducted a study in seven countries. We were surprised that though there have been big talks about women's issues and gender equality, little progress has been made. We are now demanding that women's health be put within the ambit of human rights.

Women in India

I was amazed to see the condition of women in Rajasthan. To be born a woman in Rajasthan, provided you survive foeticide, you have to be tough. Living conditions are really bad and it's surprising that women do so much work in such conditions. Also, indicators of gender inequality are the strongest in Rajasthan. Domestic violence is high. It is essential for the woman in such places to link up with NGOs working for women's rights.

'State must be accountable'

The reason why there are very minor improvements in the area of women's health and rights is because we know the issues but there is no policy decision on how to tackle them. The National Budget has no provision for these areas. The macroeconomic framework is promoting the private sector and vital social issues get relegated in the background. I feel state must be made accountable for women's health and welfare.

Malaysia vs India

In Malaysia, we have very good healthcare services for women. There are only 20 deaths per one lakh women and the fertility rate is much higher than that in India. Women are increasingly becoming politically sensitive. Also, the Ministry of Health has begun a Stop Crisis Centre for survivors of violence where they are given free counselling, information about their rights and services. India is known globally for its policy development and implementation. But being a much larger country, it still has a long way to go. However, I would compliment India for its excellent policy framework which I see is a good start.

'Malaysia must learn from India'

One conspicuous trait of Indians is that they value their heritage and history. They know their culture and are keen on preserving it. In Malaysia, people tend to forget where their roots lie.

On rural women

It is good that there are a lot of NGOs dealing with women's issues. But the real problem lies in the rural areas. I have been asking women activists in India that how many of them would actually go and work in the villages? The idea is to provide good examples from the cities but that does not mean NGOs become urban-based. NGOs like Chetana and Sahyog work for rural women in India. But such organisations are few. The needs of the rural woman are neglected. What are we actually doing for them?

'Respect the girl child and reap benefits'

STRAIGHT ANSWERS

INDU KAPOOR,
Director, Chetna

On reproductive healthcare and tackling the population problem

What are the reproductive healthcare problems prevalent among women?

Having worked with women from rural areas and slums all over the state, their poor accessibility to quality nursing homes glaringly comes to the forefront. Well-equipped nursing homes are either far away from their homes or are too costly. Despite of having hospitals closer to home there are some women who prefer the age-old method of home delivery as they find the hospital atmosphere too 'hostile and mechanical'. There are 70-80 per cent women, mainly in slums and villages, who prefer home deliveries.

What about family planning?

It's difficult to convince poor and uneducated families — having strong insecurities about the girl child — about using family planning methods. And with a high infant mortality rate, families choose to have a large number of children, with two at least being male children meant to act as economic buffers. Yet, we are constantly creating awareness by training health-workers in villages and conducting clinics twice a week in the city. We have also been building liaisons with nursing homes. With our reference, women feel relatively comfortable going to what they otherwise call 'hostile' places.

How do men react to the idea of using contraceptives and practising family planning?

It's much more difficult to convince men to practise family planning. Only around four per cent men are ready to use condoms, whereas almost all, including the women, believe that vasectomies will make them weaker.

'Once the value of the girl child is realised the population problem can be solved on its own'

What is your assessment of the status of the country's population and reproductive healthcare in ten years from now?

Both the issues depend upon the condition and position of women — economic and social. Once the value of the girl child is realised, that she can be equally depended upon for economical security, can the population problem be solved on its own. It's because of economic security that urban middle-class and rich families get self-motivated into having no more than two children.

Advocacy for Action

Project Period : July 1, 1999 - June 30, 2002

CHETNA and SAHAYOG in collaboration with ARROW, Malaysia implemented an Advocacy for Action project to assist and strengthen advocacy processes to bring about change in health and population policies and prorammes in India and particularly in the states of Gujarat. Rajasthan, Uttar Pradesh, Bihar, Uttaranchal and Jharkhand. The project was initially supported by KULU (Women and Development) and later by Danish Family Planning Association (DFPA), Denmark.

The main intended group was field-based NGOs who had rich experience of working on women's health issues but not loud-enough voices to reach the policy makers. The other target groups who could strengthen the process of advocacy were Government Health functionaries, concerned personnel from the Government Departments; researchers, trainers, academicians and representatives of media.

The project enabled the country network to be strong and enhance the skills and confidence of the NGOs in areas such as documentation, articulation and prioritisation of the issues.

Long term Objective of the Project:

Reorientation of health, population and family planning policies, programmes and services in accordance with the priority areas of the Cairo and Beijing conferences.

The priority areas of the project were:

- Sexual and Reproductive Health and rights approach included in health policies and programmes rather than a narrow maternal health and family planning focus with demographic objectives (Strategic Objective C.3 in Beijing PFA).
- Women's rights to comprehensive, accessible, affordable and quality health services throughout their lives recognized and implemented in the health care system (Strategic Objectives C.1 and para 106 in the Beijing PFA)
- Women-centered and gender-sensitive approach addressing the effects of gender inequality on women's health status and the need for women's perspectives and experiences to be included in health policies and programmes (Strategic Objective C.3 in Beijing PFA).
- Violence against women recognized as important women's health concern (Strategic Objective C.1, Para. Q and Section D. Violence Against Women).

The main project strategies were:

- Building competency and capacity of field based NGOs in monitoring and advocacy with respect to implementing the Cairo and Beijing Platform for Action and to strengthen the advocacy role at the State / District level.
- Development of information / material collection and dissemination system
- Dissemination of up-dated information related to post Beijing and Cairo conferences.